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TITLE: AN OUTCOME EVALUATION STUDY OF A PEER-
RELATIONSHIP GROUP FOR CHILDREN.

JAMES I. ISLES

Submitted in part fulfilment of the degree of doctorate in Clinical Psychology
at the University of Edinburgh, February 2000

I certify that this report is a fair and accurate account of the work carried out.

Signed:

DR. LEO HARDING





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Abstract:

The clinical effectiveness of a small peer-relationship group for children with behavioural and interpersonal difficulties was analysed using pre and post treatment measures and participant observation. A waiting list control of children with similar difficulties was used as a comparative measure. The results of questionnaire analysis revealed that there was no significant difference between pre and post questionnaire scores. However, qualitative data suggested that the group psychotherapeutic approach adopted for such difficulties was effective with individual treatment gains established.

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TITLE:

An outcome evaluation study of a peer-relationship group for children.

INTRODUCTION:

Despite the incidence of mental health problems in childhood, research on the effectiveness of child psychotherapy remains controversial. Meta-analysis does suggest that the magnitude of effect size is considerable (0.7-0.79) and equivalent to that found in adult psychotherapy (Weiss et al, 1987, 1995).

Similarly, the 'equal outcome phenomenon' is also apparent and where treatment differences are evident, they favour behavioural approaches. However, the validity of child psychotherapy research has been challenged by Barnett et al (1991) on the basis of insufficient studies and poor methodology.

The status of group therapy is also controversial with little evidence of a superiority effect demonstrated over individual therapy (Casey and Berman, 1985). Positive results for group approaches to adolescent problems are established, particularly in the area of social skills training (Schnneider and Byren, 1985, Beefman and Orvaschel, 1994). However, there is a paucity of research into group therapy for younger children where studies are often descriptive and lack control measures (Spence, 1989; Kadzin, 1994). In a review of empirical outcome research, Abramowitz (1976) for example, failed to find convincing evidence for the effectiveness of group therapy using behaviour modification, play, verbal or activity approaches.

Kolvin et al (1981) Newcastle community programmes, found that play group therapy (non-directive) and 'nurture' work was superior to parent-teacher and non-intervention. The effect was stronger for children, aged 7-8 who displayed neurotic rather than conduct problems and effects were maintained at 30-36 months follow up. However, the overall results failed to establish differential treatment effects.

There are of course considerable methodological problems which beset child psychotherapy research. For example, diagnostic issues, maturational effects, multi-agency involvement, the situation-specific nature of many childhood behaviours, and discrepancies between therapists, teachers, peer-group sociometry and self-report measures. Group therapy further suffers from unsatisfactory definitions of the primary treatment variable (McMillan et al, 1980; Casey and Berman, 1985; Spence, 1989; Weiss and Weiss, 1993; Kadzin, 1994)

There is clearly a need for outcome research over the whole range of interventions found in child psychotherapy, both to establish treatment efficacy and to resolve apparent epistemological issues.

AIM OF STUDY / HYPOTHESIS:

The present study attempts to evaluate the effectiveness of a single peer-relationship group for children. The small numbers involved in the evaluation will preclude generalisation.

It is predicted that the treatment group will show clinical improvements on several outcome measures when compared with a waiting list control group.

METHOD:

The group under study is part of a series of peer-relationship groups which are run by an experienced therapist working with a local Department of Child and Family Psychiatry. The therapist invited the author to participate in a group whilst the author was on placement with the Department of Child Clinical Psychology. The study was therefore opportunistic and quasi-experimental with pre-test, post test and control group measurements (Campbell and Stanley, 1963).

The psychiatric team was approached to seek permission to evaluate the group and feedback from several psychiatrists concerning the protocol was adopted.

SUBJECTS - TREATMENT GROUP:

5 boys and 2 girls between 8 and 12 years of age had been invited to attend the group. (Mean age - 10.1 years). All the children had attended a play-therapy group run by the therapist in the preceeding year. Two of the boys, however had attended only part of the programme. The children had all been referred for peer-relationship difficulties and/or conduct problems and permission to include them in the study was sought from parents and the children themselves. Three of the children (2 boys and 1 girl) had been attending a special behavioural unit within mainstream education for several months prior to the commencement of the group.

In this study, 1 boy attended only one session and dropped out. Otherwise all participants attended at least 6 from 9 sessions. One child was considered to be extremely vulnerable and the

responsible social worker had requested that this child be omitted from the study. The study therefore reports on 4 boys and 1 girl (Mean age - 9.8 years).

CONTROL GROUP:

12 referral letters were selected from the Department of Child and Family Psychiatry waiting list by the author and the group therapist. Criteria for selection was based upon an age range of 8-12 years and indices of conduct and/or peer group relationship problems. An attempt was made to match for age and gender. The referring agents were approached by telephone to seek permission to contact the children's parents. Six boys and two girls were selected randomly from the selection list and their parents subsequently contacted by telephone. All parents agreed to meet to discuss the study and subsequently gave permission to include their children. Permission was also sought from the children. Parent interviews confirmed that the children included in the study were having peer-relationship difficulties and /or conduct problems.

5 boys and 1 girl (Mean age - 8.6 years) provided matched scorings on the outcome questionnaires and were included in the study as a waiting list control group (Figures 1-3).

CLINICAL INTERVENTION:

The peer relationship group ran for 10 sessions each of one hour duration. The final session involved a review of the children's experience of the group and the therapist's observations. Written and verbal feedback was given to each parent by the therapist.

GROUP THERAPIST:

The therapist is an experienced group leader trained in child and adolescent psychotherapy. The therapist's philosophy and approach to group methods are influenced by Haim G. Ginot and described in his book ' Group Psychotherapy With children: The Theory and Practice of Play-Therapy'.

OUTCOME MEASURES:

A: TREATMENT AND CONTROL GROUPS - PRE AND POST QUESTIONNAIRES.

(Refer Appendix 1.)

1. HARTER'S SELF-ESTEEM QUESTIONNAIRE -MODIFIED (HSE)

The HSE has been modified for use in Scottish School Children by Hoare et al (1993).

The questionnaire was administered to the children by either the author or the group therapist. The HSE has 36 items yielding 6 subscales related to self-esteem :-

- 1.Scholastic Performance
- 2.Social Acceptance.
- 3.Athletic Competence.
- 4.Physical Appearance.
- 5.Behaviour.
- 6.Global self-esteem.

2. RUTTER'S SCALE A (2).

Rutter's Scale A (2) was completed by parents. The scale contains 31 items which yield a Total Score (cut off for

dysfunction at score 13 and above) The scale also yields two subscales - Emotional Disorder and Conduct Disorder with primacy given to the highest score for diagnostic purposes. (Rutter and Graham, 1968, Rutter et al, 1965, 1970)

3. CONNERS PARENT SYMPTOM QUESTIONNAIRE (PSQ) - CONNORS (1970).

This 48 item scale was also completed by parents. The PSQ provides subscales in the following domains:-

1. Conduct problems.
2. Learning problems.
3. Psychosomatic problems.
4. Impulsivity-Hyperactivity.
5. Anxiety.
6. Hyperactivity.

The above questionnaires were re-administered approximately 4-6 weeks following termination of the group.

B: PARTICIPANT OBSERVATION OF TREATMENT GROUP.

The author observe 6 sessions of the group programme as a participant observer. Permission for the author to participate and observe was sought from the children. The group therapist would not allow the sessions to be audiotaped, videotaped or observed from a one-way mirror. The therapist had discussed the issue of observation with children in previous groups and had concluded that children found such observation intrusive. Following each group session where the author was present, both the author and therapist collated their observations of the group

thus giving a degree of internal validity to the findings.

C: FOLLOW-UP INTERVIEWS WITH CHILDREN AND PARENTS.

Approx. 4-6 weeks following the group termination, the author interviewed both children and parents to ascertain

- a) the degree of enjoyment experienced by the child whilst attending the group.
- b) subjective ratings of change/no change in child's behaviour.

RESULTS.

#1. The results of initial assesement suggests that both groups were matched on questionnaire measures, with the exception of the Learning Problems subscale of the PSQ (Figures 1-3).

Questionnaire differences were not significant (Mann-Whitney, 2-tailed) and both groups demonstrated behavioural disorders of clinical significance.

Post-treatment results suggests that the treatment group improved on the HSE subscales of Scholastic Performance, Social Acceptance and Behavior (Figures 4-6). However parental assessment of child behavior on the Rutter Scale A (2) and PSQ failed to demonstrate improvement. The differences between scores pre and post group are not statistically significant.(Wilcoxin, 1-tailed).

The results of pre-and post assesement for the control group suggests that the children's behaviour has become slightly more disturbed with an increased score for Conduct Problems on the PSQ. (Figures 7-9) However, differences are not statistically significant (Wilcoxin, 1 tailed)

FIGURES 1-3: PRE-GROUP ASSESSMENT - TREATMENT AND CONTROL GROUPS.

FIG.1.

HARTERS SELF ESTEEM QRE:

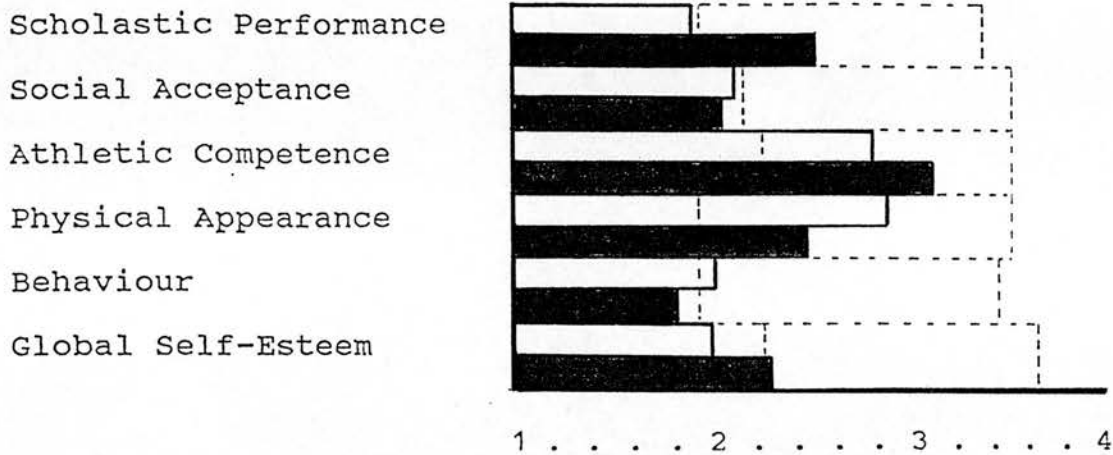


FIG.2.

RUTTERS SCALE A (2) - PARENTS.

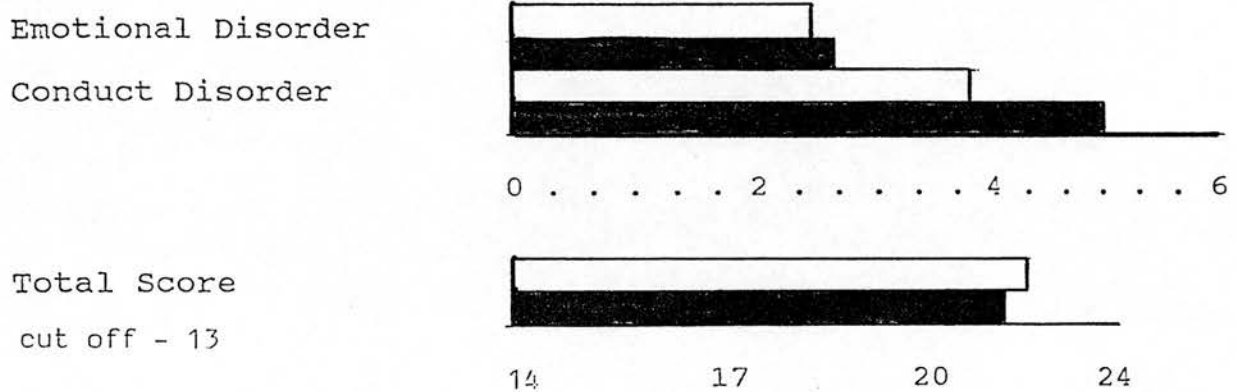
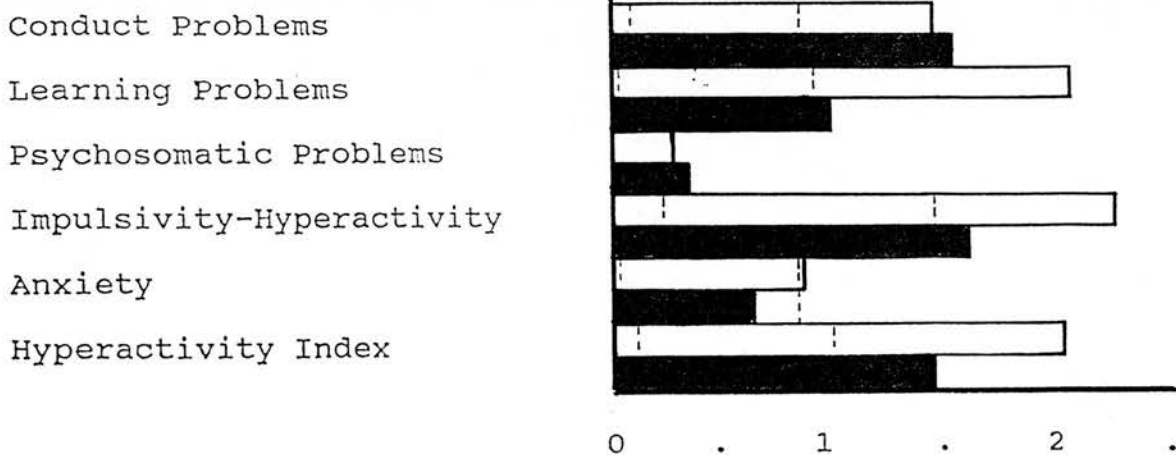


FIG. 3.

CONNORS PSQ



KEY:

Treatment group

Control group

Normal range \pm 1 s.d.

FIGURES 4-6. TREATMENT GROUP - PRE AND POST QUESTIONNAIRE RESULTS.

FIG. 4. HARTERS SELF ESTEEM QRE:

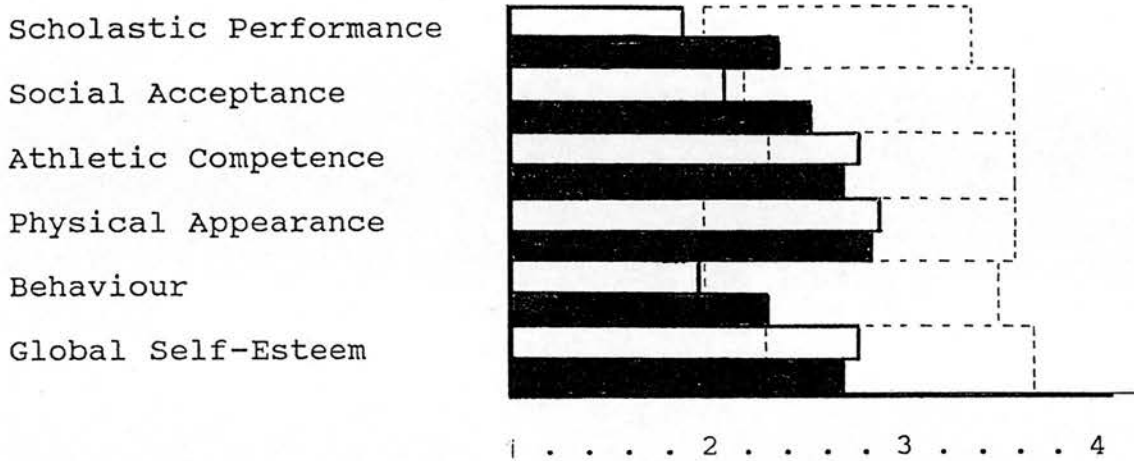


FIG. 5. RUTTERS SCALE A (2) - PARENTS.

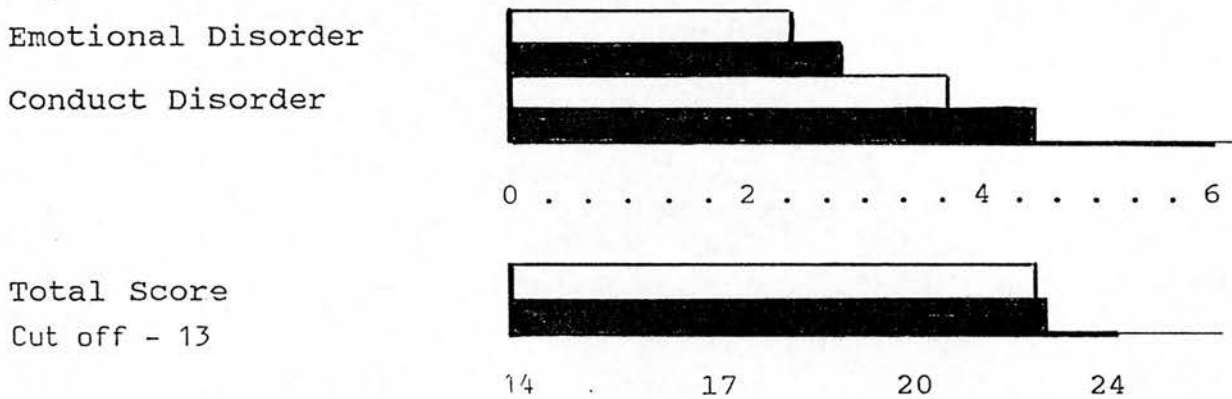
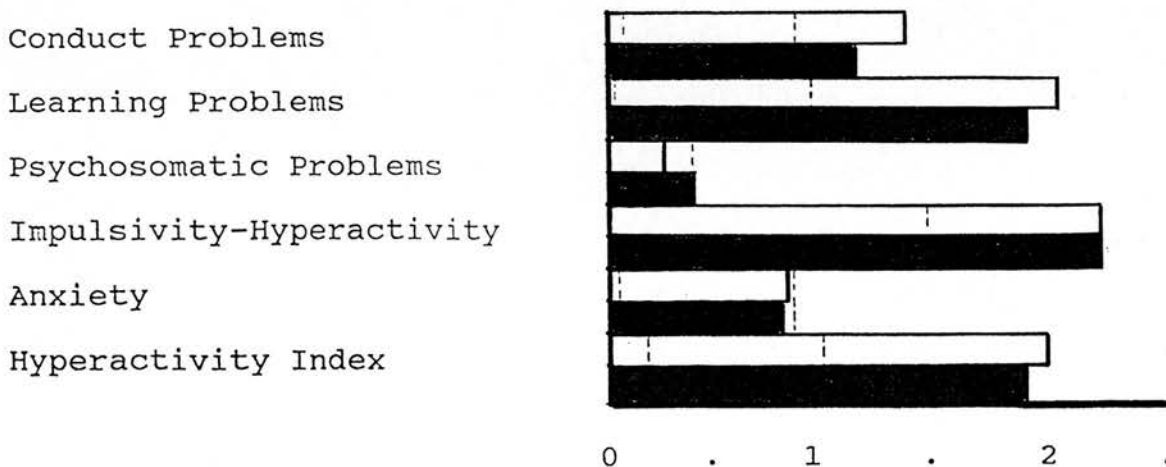
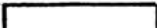




FIG. 6. CONNORS PSQ



KEY:

Treatment group pre  post   Normal range ± 1 s.d.

FIGURES 7-9: CONTROL GROUP - PRE AND POST ASSESSMENT.

FIG. 7. HARTERS SELF ESTEEM QRE:

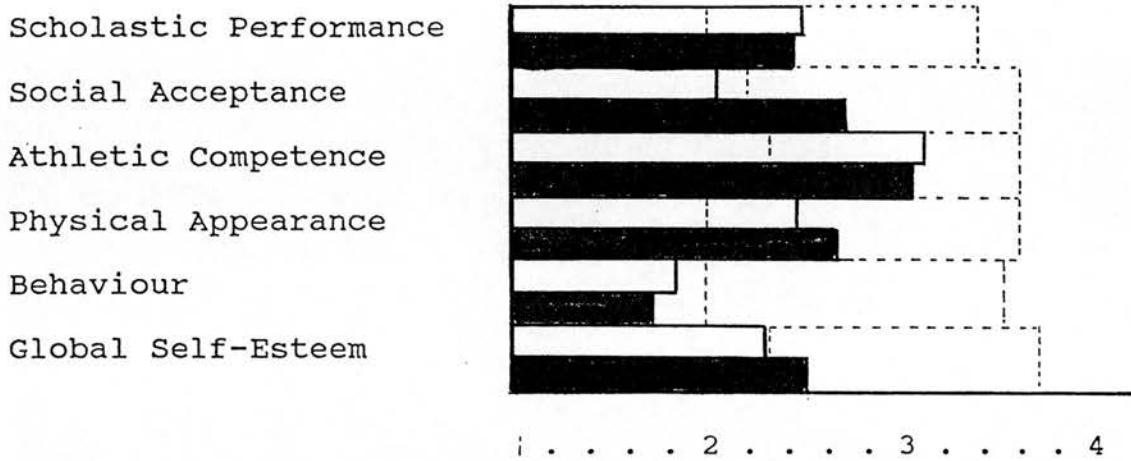


FIG. 8 RUTTERS SCALE A (2) - PARENTS.

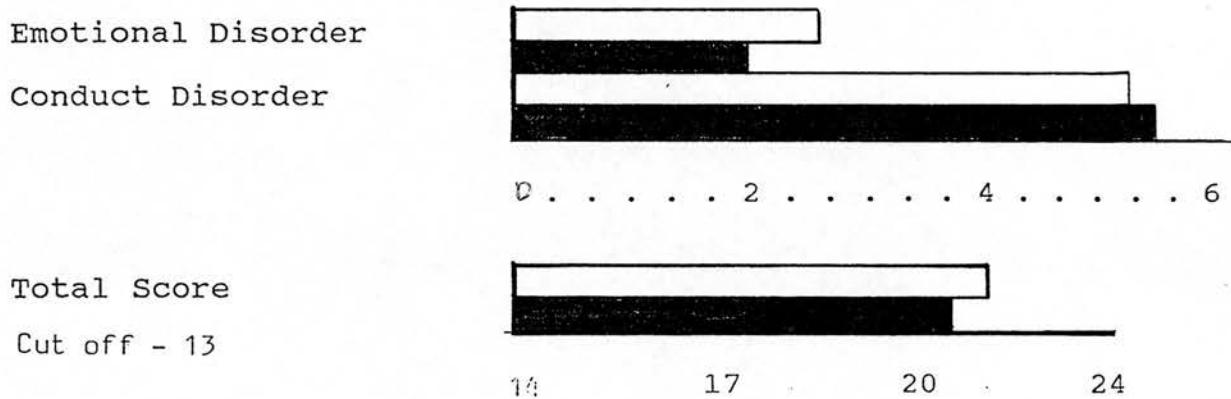
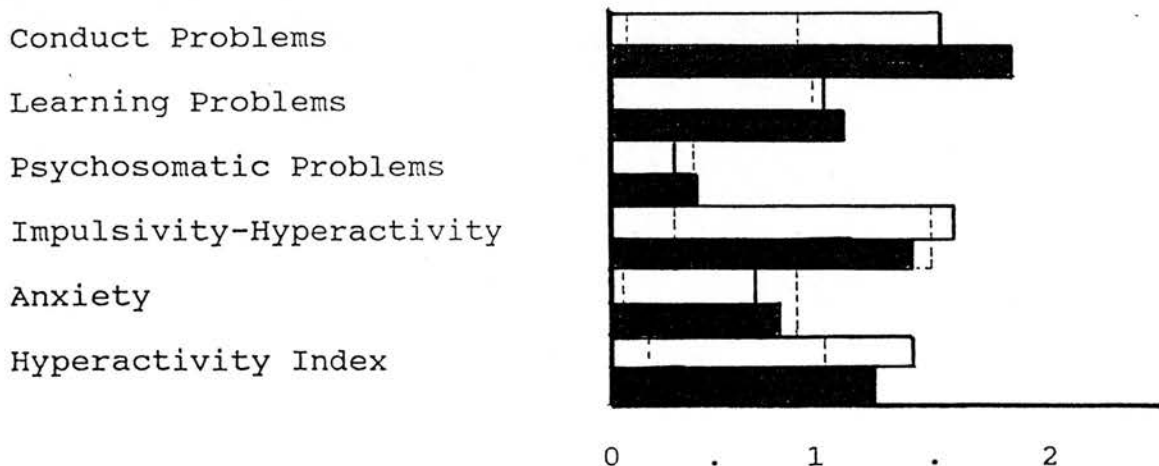


FIG. 9 CONNORS PSQ



KEY:

pre
post

Normal range + 1 s.d.

Normal range + 1 s.d.

#2. Observation of the group over 5 sessions revealed a richness of data related to child-child and therapist-child interactions. Within the necessary ground rules, the children were allowed free expression in play. The therapist observed the children's verbal and non-verbal interactions and occasionally spoke either to the group or to an individual. Suggestions or interpretations were made softly and either directly to an individual or indirectly through the group. In general the children stopped their play and responded with apparent thought or verbal response. For example (with false names):-

Simon had been engaged in a trolley ride with John. Simon prevented Alex from participating by pushing him away. The therapist stopped the play and asked the group to consider how Alex may be feeling. Subsequently Alex was asked to express how he felt and Simon to reflect on both his behaviour and the response of others.

The above example illustrates a typical therapist intervention designed to facilitate safe disclosure and change through reflection and peer group processes. (Pfeifer, 1992, Reid and Kolvin, 1993) The author observed subtle behavioural changes in all group participants over the life-span of the group. Empirical observations thus confirm that this approach to the treatment of peer-relationship problems is at the very least, a therapeutic process.

#3. Follow-up interviews:

All the children enjoyed the group with mean scoring on a likert

scale of 4.6 (1-5 scale).

Child (A):

(A) had previously attended one group. (A) didn't feel that anything had been learned from attending the group and could not recall the feedback given by the group therapist.

In contrast, (A)'s mother believed that (A) had derived some benefit -

".....spends more time listening to other kids and more able to see their point of view".

(A)'s peer-relationships continued to be problematic however and behaviour at home remained difficult.

Child (A)'s post-treatment questionnaires suggests that (A) had improved on several indices of self-esteem.

Child (B):

Child (B) had attended 4 sessions of a previous group. (B) thought that the group had helped to -

"make me better at making friends"

- although was unsure as to how this had been achieved.

At school (B) felt that both school work and behaviour had improved. (B) recalled feedback from the therapist that he had been able to stop hitting others when angry.

(B)'s mother believed that the group had helped (B) to feel more relaxed with other children with improvement in communication skills evident. However, (B)'s behaviour at home was still problematic and (B) had been suspended from school due to truancy.

On post-treatment questionnaire assesement, Child (B) showed a

small reduction on the hyperactivity subscales of the PSQ and increased scores on the HSE.

Child (C):

(C) had attended two group previously and stated that the group was beneficial -

"It helped me show me how to make friends ...how to get along with people".

(C) gave an example of sharing goals -

"when we built the sand-castle..it was the highest one because we did it together".

(C)'s parents agreed that (C) had learned to share more with others and had been more tolerant of his younger siblings.

Post-treatment assessment revealed improvement on the HSE and reductions on both the Rutter Scale A (2) total score and the Conduct Problems subscale of the PSQ.

Child (D):

(D) had attended two groups previously. (D) felt that the group was not always enjoyable due to several incidents when (D) had felt "picked on" by the other children. (D) didn't feel that anything had been learned from his attendance at 3 groups. On prompting however, (D) was able to recall feedback from the therapist and acknowledged that some attempts had been made to implement this feedback -

"I'm trying not to rush in and take over other children when they're playing"

(D)'s mother believed that (D) had not benefited from the group.

Post-treatment assessment demonstrated improvement on 4 of the 5 HSE subscales.

Child (E):

(E) had attended 1 group previously. (E) felt that the group had promoted behavioural change -

"I've learned to try and get on better with others" - (E) was unsure however, as to how this had been achieved.

(E)'s parents thought that change had been evident following attendance at the second group and that (E) was now -

"more biddable... and mixes with others better....although still has tantrums".

(E)'s parents reported that (E) continued to have problems at school - with occasional episodes of bullying other children evident.

Post-treatment assessment showed that whilst (E) had improved on the Behaviour subscale of the HSE, a deterioration was noted on the PSQ.

Summary of results:

Pre and post questionnaire assessment failed to demonstrate significant clinical change in the treatment group. However, follow-up interviews suggests that most of the children have made some improvement in their social behaviours. The children found the group enjoyable and participant observation confirms this approach to working with children to be therapeutic. There is however, insufficient evidence to support the hypothesis.

DISCUSSION:

To the causal observer, group-play therapy may appear to involve simply, a group of children engaging in unstructured, chaotic play. However, beyond the apparent chaos, the informal group structure appears to facilitate disclosure and promote reflection on both positive and negative behaviours. Participant observation in this study suggests that this particular group provided the necessary ingredients to allow children to explore issues, both symbolically through play and in reality, through the group experience. The therapist's interventions appeared to be highly relevant and thought provoking for the children with subsequent changes in behaviour evident over the period of the group programme. Such changes are confirmed by follow-up interviews, where on the whole parents and children thought that the group had been beneficial and had effected change. However, such change is not reflected on the outcome questionnaire measures thus leading to rejection of the hypothesis.

It is possible that the questionnaires in this study are inadequate in measuring social-behavioural change.

Alternatively, the gains made during the group sessions failed to generalise sufficiently beyond the group setting. A lack of positive change at post-treatment is however, not unusual in group therapy and may reflect a 'sleeper effect'. That is, the benefits gained from therapy may not be obvious until longer term follow-up. (Reid and Kolvin, 1993).

The positive results evident in two individuals who were also attending a specialist school unit, may have been confounded by school interventions. This variable could have been controlled

for by establishing teacher baseline ratings of these children and establishing subsequent ratings throughout the period of the study.

A further variable not controlled for in this study was the family background and the possible maintenance effects on child behaviour.

In conclusion, this study failed to support the hypothesis that the treatment group would show significant clinical change.

However, qualitative evidence derived from participant observation of the group process and from follow-up interviews, suggests that important changes did occur in the treatment group. Given the lack of research into this area, there is considerable scope for both outcome and process research. In particular it would be useful to evaluate the peer-relationship groups referred to herein over a series and with long term follow up.

Word count: 2,500 (excluding references).

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HARTERS SELF-ESTEEM QUESTIONNAIRE.

Appendix 1

WHAT I AM LIKE

Name _____ Age _____ Birthday _____ Class _____
 Boy or Girl(Please Circle)
 Child number _____

SAMPLE SENTENCE

	Really True for me	Sort of True for me				Sort of True for me	Really True for me
(a)	<input type="checkbox"/>	<input type="checkbox"/>	Some kids would rather play outside in their spare time	BUT	Other kids would rather watch T.V.	<input type="checkbox"/>	<input type="checkbox"/>

1.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids feel they are very good at their school work	BUT	Other kids worry about whether they can do their school work	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids find it hard to make friends	BUT	Other kids find it's pretty easy to make friends	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids do very well at all kinds of sports	BUT	Other kids don't feel they are good when it comes to sports	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are happy with the way they look	BUT	Other kids are not happy with the way they look	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids often do not like the way they behave	BUT	Other kids usually like the way they behave	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are often unhappy with themselves	BUT	Other kids are pretty pleased with themselves	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids feel they are just as clever as other kids	BUT	Other kids aren't so sure and wonder if they are as clever	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids have a lot of friends	BUT	Other kids don't have very many friends	<input type="checkbox"/>	<input type="checkbox"/>

	Really True for me	Sort of True for me			Sort of True for me	Really True for me
9.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids wish they could be a lot better at sports	BUT	Other kids feel they are good enough at sports	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are happy with their height or weight	BUT	Other kids wish their height or weight was different	<input type="checkbox"/>
11.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids usually do the right thing	BUT	Other kids often don't do the right thing	<input type="checkbox"/>
12.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids don't like the way they are leading their life	BUT	Other kids do like the way they are leading their life	<input type="checkbox"/>
13.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are pretty slow in finishing their school work	BUT	Other kids can do their school work quickly	<input type="checkbox"/>
14.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids would like to have a lot more friends	BUT	Other kids have as many friends as they want	<input type="checkbox"/>
15.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids think they could do well at any new sport	BUT	Other kids are afraid they do not do well at new sports	<input type="checkbox"/>
16.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids wish their body was different	BUT	Other kids like their body the way it is	<input type="checkbox"/>
17.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids usually behave the way they know they're supposed to	BUT	Other kids often don't behave the way they're supposed to	<input type="checkbox"/>
18.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are happy with themselves as a person	BUT	Other kids are often not happy with themselves	<input type="checkbox"/>
19.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids often forget what they learn	BUT	Other kids can remember things easily	<input type="checkbox"/>
20.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are always doing things with a lot of kids	BUT	Other kids usually do things by themselves	<input type="checkbox"/>

	Really True for me	Sort of True for me			Sort of True for me	Really True for me
21.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids feel they are better at sports than their friends	BUT	Other kids don't feel they can play as well	<input type="checkbox"/>
22.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids wish they looked different	BUT	Other kids like the way they look	<input type="checkbox"/>
23.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids usually get in trouble because of things they do	BUT	Other kids don't do things that get them into trouble	<input type="checkbox"/>
24.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids like the kind of person they are	BUT	Other kids often wish they were someone else	<input type="checkbox"/>
25.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids do very well at their classwork	BUT	Other kids don't do very well at their classwork	<input type="checkbox"/>
26.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids wish more people their own age liked them	BUT	Other kids feel that most people their own age do like them	<input type="checkbox"/>
27.	<input type="checkbox"/>	<input type="checkbox"/>	In games and sports some kids usually watch instead of play	BUT	Other kids usually play rather than just watch	<input type="checkbox"/>
28.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids wish something about their face or hair was different	BUT	Other kids like their face and hair the way they are	<input type="checkbox"/>
29.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids do things they know they shouldn't do	BUT	Other kids hardly ever do things they know they shouldn't do	<input type="checkbox"/>
30.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are very happy being the way they are	BUT	Other kids wish they were different	<input type="checkbox"/>
31.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids have trouble working out the answers in school	BUT	Other kids almost always can work out the answers	<input type="checkbox"/>
32.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are popular with others their own age	BUT	Other kids are not very popular	<input type="checkbox"/>

	Really True for me	Sort of True for me			Sort of True for me	Really True for me	
33.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids don't do well at new outdoor games	BUT	Other kids are good at new games right away	<input type="checkbox"/>	<input type="checkbox"/>
34.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids think that they are good looking	BUT	Other kids think that they are not very good looking	<input type="checkbox"/>	<input type="checkbox"/>
35.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids behave themselves very well	BUT	Other kids often find it hard to behave themselves	<input type="checkbox"/>	<input type="checkbox"/>
36.	<input type="checkbox"/>	<input type="checkbox"/>	Some kids are not happy with the way they do a lot of things	BUT	Other kids think the way they do things is fine	<input type="checkbox"/>	<input type="checkbox"/>

THANK YOU FOR YOUR HELP

STRICTLY CONFIDENTIAL

FOR OFFICE USE ONLY

SCALE A (2)

TO BE COMPLETED BY PARENTS

Name of Child

Boy/Girl

Date of Birth

Address

School

HOW TO FILL IN THIS FORM

The questionnaire asks about various kinds of behaviour that many children show at some time. Please give the answers according to the way your child has been during the PAST 12 MONTHS.

HEALTH PROBLEMS

Below is a list of minor health problems which most children have at some time. Please tell us how often each of these happens with your child by putting a cross in the correct box.

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USE ONLY

	Never	Occasionally, but not as often as once per week	At least once per week	
A. Complains of headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Has stomach-ache or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma or attacks of wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Wets the bed or pants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Soils or loses control of bowels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Has temper tantrums (that is, complete loss of temper with shouting, angry movements, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Had tears on arrival at school or refused to go into the building ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Truants from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS. Please place a cross in the box by the correct answer.

I. Does he/she stammer or stutter? ☐ No. ☐ Yes—mildly. ☐ Yes—severely.

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USE ONLY

☐

II. Is there any difficulty with speech other than
stammering or stuttering? ☐ No. ☐ Yes—mild. ☐ Yes—severe.

If "Yes", please describe the difficulty:

.....
.....

☐

III. Does he/she ever steal things? ☐ No. ☐ Yes—occasionally. ☐ Yes—frequently.
If "Yes" (occasionally or frequently),
does it involve

☐ minor pilfering of pens, sweets, toys, small sums of money, etc.

☐ stealing of big things

☐ both minor pilfering *and* stealing of big things

is stealing done

☐ in the home

☐ elsewhere

☐ both in the home *and* elsewhere

is stealing done

☐ on own

☐ with other children or adults

☐ sometimes on own, sometimes with others

☐ ☐

IV. Is there any eating difficulty? ☐ No. ☐ Yes—mild. ☐ Yes—severe.
If "Yes", is it

☐ faddiness

☐ not eating enough

☐ eating too much

☐ other, please describe:

.....
.....

☐
☐
☐

V. Is there any sleeping difficulty? ☐ No. ☐ Yes—mild. ☐ Yes—severe.
If "Yes", is it difficulty in

☐ getting off to sleep

☐ waking during the night

☐ waking early in the morning

☐ other, please describe:

.....
.....

☐
☐

Below are a series of descriptions of behaviour often shown by children. After each statement are three columns—"Doesn't Apply", "Applies Somewhat", and "Certainly Applies". If your child definitely shows the behaviour described by the statement place a cross in the box under "Certainly Applies". If he or she shows the behaviour described by the statement but to a lesser degree or less often, place a cross under "Applies Somewhat". If, as far as you are aware, your child does not show the behaviour, place a cross under "Doesn't Apply".

Please put **one** cross against **each** statement.

STATEMENT	Doesn't Apply	Applies Somewhat	Certainly Applies	FOR OFFICE USE ONLY
1. Very restless, has difficulty staying seated for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Squirmy, fidgety child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Often destroys own or others' property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Frequently fights or is extremely quarrelsome with other children ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Not much liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Often worried, worries about many things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Tends to be on own—rather solitary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Irritable. Is quick to 'fly off the handle'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Often appears miserable, unhappy, tearful or distressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has twitches, mannerisms or tics of the face or body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Frequently sucks thumb or finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Frequently bites nails or fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Is often disobedient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Cannot settle to anything for more than a few moments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Tends to be fearful or afraid of new things or new situations ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Fussy or over-particular child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Often tells lies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Bullies other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ARE THERE ANY OTHER PROBLEMS?

Signature: Mr./Mrs. _____

THANK YOU VERY MUCH FOR YOUR HELP

CONNORS PARENT SYMPTOM QUESTIONNAIRE.

Parents' Questionnaire

Name of Child:

Date:

Please answer all questions. Beside each item below, indicate the degree of the problem by a tick (✓)

		Not at all	Just a little	Pretty much	Very much
1	Picks at things (nails, fingers, hair, clothing)				
2	Cheeky to grown-ups				
3	Problems with making or keeping friends				
4	Excitable, impulsive				
5	Wants to run things				
6	Sucks or chews (thumb, clothing, blankets)				
7	Cries easily or often				
8	Carries a chip on his shoulder				
9	Daydreams				
10	Difficulty in learning				
11	Restless in the "squirmy" sense				
12	Fearful (of new situations; new people or places; going to school)				
13	Restless, always up and on the go				
14	Destructive				
15	Tells lies or stories that aren't true				
16	shy				
17	Gets into more trouble than others same age				
18	Speaks differently from others of the same age (baby talk; stuttering; hard to understand)				
19	Denies mistakes or blames others				
20	Quarrelsome				
21	Pouts and sulks				
22	Steals				
23	Disobedient or obeys but resentfully				
24	Worries more than others (about being alone, illness or death)				
25	Fails to finish things				
26	Feelings easily hurt				

		Not at all	Just a little	Pretty much	Very much
27	Bullies others				
28	Unable to stop a repetitive activity				
29	Cruel				
30	Childish or immature (wants help he shouldn't need; clings; needs constant reassurance)				
31	Distractibility or attention span a problem				
32	Headaches				
33	Mood changes quickly and drastically				
34	Doesn't like or doesn't follow rules or restrictions				
35	Fights constantly				
36	Doesn't get along well with brothers or sisters				
37	Easily frustrated in efforts				
38	Disturbs other children				
39	Basically an unhappy child				
40	Problems with eating (poor appetite; doesn't sit at the table)				
41	Stomach aches				
42	Problems with sleep (can't fall asleep; up too early; up in the night)				
43	Other aches and pains				
44	Vomiting or nausea				
45	Feels cheated in family circle				
46	Boasts and brags				
47	Lets self be pushed around				
48	Bowel problems (frequently loose; irregular habits; constipation)				

APPENDIX 2 : INDIVIDUAL QUESTIONNAIRE RESULTS.

(A)

D.O.B: _____

QUESTIONNAIRE

HARTERS SELF ESTEEM

Scholastic Performance
Social Acceptance
Athletic Competence
Physical Appearance
Behaviour
Global Self Esteem

SCORES		NORMS
Pre	Post	\bar{X} (S.d.)
2.7	3.8	2.73
2.8	3.7	3.05
3.2	3.7	2.97
3.8	3.5	2.92
3	2.7	2.59
4	3.8	3.04
1	1	
5	5	
23	23	<13
1.7	1.7	0.53
2.5	2.25	0.54
0	0	0.18
2.75	3	0.92
0.75	1	0.42
2.5	2.4	0.66

0.61
0.69
0.67
0.69
0.55
0.54

RUTTERS SCALE A (2)- PARENTS

Emotional Disorder
Conduct Disorder
Total Score

PARENT SYMPTOM QRE.

Conduct Problems
Learning Problems
Psychosomatic Problems
Impulsivity-Hyperactivity
Anxiety
Hyperactivity Index

0.38
0.52
0.26
0.60
0.47
0.44

NAME:

(B)

D.O.B:

QUESTIONNAIRE

HARTERS SELF ESTEEM

Scholastic Performance
Social Acceptance
Athletic Competence
Physical Appearance
Behaviour
Global Self Esteem

SCORES		NORMS	
Pre	Post	\bar{X} (S.d.)	
2	2	2.69	0.6
1.5	2.2	3.04	0.65
3.3	3.1	2.97	0.67
3.5	3.8	2.69	0.23
2	2	2.57	0.57
2.5	3.2	3.04	0.61
2	2	<13	
1	2		
1.5	1.4		
0.75	0.7	0.53	0.38
1.75	1	0.54	0.52
0.4	0.4	0.18	0.26
1.25	0.75	0.92	0.60
0.5	0.25	0.66	0.44
1.5	0.9	0.42	0.42

RUTTERS SCALE A (2)- PARENTS

Emotional Disorder
Conduct Disorder
Total Score

PARENT SYMPTOM QRE.

Conduct Problems
Learning Problems
Psychosomatic Problems
Impulsivity-Hyperactivity
Anxiety
Hyperactivity Index

NAME: (C)

D.O.B: _____

QUESTIONNAIRE

HARTERS SELF ESTEEM

Scholastic Performance
 Social Acceptance
 Athletic Competence
 Physical Appearance
 Behaviour
 Global Self Esteem

SCORES		NORMS
Pre	Post	\bar{X} (S.d.)
1.5	2.5	2.74
3	3	3.02
3	2.25	3.04
2.3	2.25	2.94
1.3	2	2.62
2.5	2.2	3.06
3	3	
6	6	
26	17	<13
1.5	1.1	0.53
1.5	1.25	0.54
0	0	0.18
2.5	2.5	0.92
0.5	0.5	0.42
1.9	1.6	0.66

0.66
 0.67
 0.66
 0.67
 0.65
 0.66

RUTTERS SCALE A (2)- PARENTS

Emotional Disorder
 Conduct Disorder
 Total Score

PARENT SYMPTOM QRE.

Conduct Problems
 Learning Problems
 Psychosomatic Problems
 Impulsivity-Hyperactivity
 Anxiety
 Hyperactivity Index

0.38
 0.52
 0.26
 0.60
 0.47
 0.44

NAME: (D)

D.O.B: _____

QUESTIONNAIRE

HARTERS SELF ESTEEM

Scholastic Performance
 Social Acceptance
 Athletic Competence
 Physical Appearance
 Behaviour
 Global Self Esteem

SCORES		NORMS
Pre	Post	\bar{X} (S.d.)
1.2	1.8	2.74
1.2	1.7	3.02
2.8	2.8	3.04
1.8	2.2	2.94
1.7	2.25	2.62
1.7	2.2	3.06
2	3	
3	6	
23	28	<13
1.25	1.7	0.53
3	2.75	0.54
0.2	0.6	0.18
3.0	3	0.92
0.75	0.25	0.42
2.4	2.3	0.66

0.66
 0.67
 0.66
 0.67
 0.65
 0.66

RUTTERS SCALE A (2)- PARENTS

Emotional Disorder
 Conduct Disorder
 Total Score

PARENT SYMPTOM QRE.

Conduct Problems
 Learning Problems
 Psychosomatic Problems
 Impulsivity-Hyperactivity
 Anxiety
 Hyperactivity Index

0.38
 0.52
 0.26
 0.60
 0.47
 0.44

NAME: (E)

D.O.B: _____

QUESTIONNAIRE

HARTERS SELF ESTEEM

Scholastic Performance
 Social Acceptance
 Athletic Competence
 Physical Appearance
 Behaviour
 Global Self Esteem

SCORES		NORMS
Pre	Post	\bar{X} (S.d.)
2	1.8	2.74
2	2.2	3.02
1.7	1.7	3.04
3	2.3	2.94
2	3	2.62
3.2	2.2	3.06
4	5	
4	8	
26	32	<13
2	1.7	0.4
2	2.5	0.43
0.6	1	0.17
1.75	2	0.80
2	2.25	0.49
2	2.6	0.52

0.66
 0.67
 0.66
 0.67
 0.65
 0.60

RUTTERS SCALE A (2)- PARENTS

Emotional Disorder
 Conduct Disorder
 Total Score

PARENT SYMPTOM QRE.

Conduct Problems
 Learning Problems
 Psychosomatic Problems
 Impulsivity-Hyperactivity
 Anxiety
 Hyperactivity Index

0.36
 0.38
 0.28
 0.59
 0.57
 0.34

TITLE: THE PSYCHOLOGICAL ASSESSMENT AND INTERVENTIONS
OF THE EDUCATIONAL AND EMOTIONAL DIFFICULTIES IN
A MALE ADOLESCENT.

JAMES I. ISLES

Submitted in part fulfilment of the degree of doctorate in Clinical Psychology
at the University of Edinburgh, February 2000

I certify that this report is a fair and accurate account of the work carried out.

Signed: *Leo Harding*

DR. LEO HARDING

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TITLE:

The psychological assessment and intervention for the educational and emotional difficulties in a male adolescent.

THE CLIENT:

Tim aged 13, was admitted to a child in-patient psychiatric unit with a major depressive episode. His admission was precipitated by suicidal urges and panic disorder. He was described by his parents as a sensitive boy with a disposition to worry about health and safety issues. He was viewed as being very dependent upon his mother, although in recent years had demonstrated minor degrees of oppositional behaviour. His developmental stages were normal although he had experienced hypoxia during birth and subsequently had been noted to be somewhat clumsy .

Tim's father is a health professional and his mother a housewife. Tim has a younger brother whom he is close to. The family have not experienced major stressors in the past few years. There are however some unresolved issues concerning the influence of a paternal grandmother. Tim has an uncle who experienced depression in childhood.

Following Psychiatric assessment, the Consultant Psychiatrist formulated Tim's depression in terms of both an endogenous factor and an identity crisis related to academic expectations and separation conflict. Subsequently the Psychiatrist invited the family for family counselling and engaged Tim in individual therapy . An anti-depressant regime initiated by Tim's G.P. prior to admission was continued.

CLINICAL PSYCHOLOGY INVOLVEMENT:

Tim quickly settled into the psychiatric unit and his mood improved due to psychotropic medication. His intellectual ability had been assessed by the Unit teacher as average using the Ravens Progressive Matrices. This estimate however, did not concur with his own school's expectations of Tim's ability and a referral was made to Clinical Psychology for intellectual assessment. There was some urgency in this referral due to a need to assess Tim's abilities prior to returning to his own school. Despite the possible confounding effects of anti-depressant medication on IQ scores (Cepedo, 1989), the Weschler Intelligence Scale for Children III (WISC III) was administered to Tim. At the time of assessment, he was not considered to be clinically depressed.

The WISCIII revealed a high Verbal IQ score of 128 and a relatively low Performance IQ score of 85. (Refer Appendix A. p17)

The marked Verbal > Performance discrepancy was attributed by the trainee, in consultation with his supervisor to the following variables-

1. the possibility of visuo-spatial and/or visuo-motor difficulties as shown by low scores on Picture Completion (scaled score = 7) , Picture Arrangement (score = 6) and Symbol Search (score = 5). (Glasser and Zimmerman, 1967, Banas and Wills, 1988)
2. an observed visual problem due to medication or visual deficit.
3. observed test anxiety and other attentional / emotional variables. A digit span score of 7 was also attributed to anxiety although a short term auditory memory problem was considered.

The Unit school teacher had not observed educational difficulties in Tim's school work although Speech and Language assessment suggested that Tim has problems with short-term auditory memory and a minor expressive language difficulty.

An Occupational Therapy assessment revealed that Tim has a minor motor learning difficulty which may influence Performance IQ testing. (Banas and Wills, 1988, Teeter, 1989)

On debriefing the results of the WISC III with Tim, it became apparent that he had been having difficulties with specific school subjects. In geography for example, he had been finding it difficult to recall places on maps and has difficulty recalling graphical material in general. However, Tim did not report problems with topographical memory. It had been of concern to Tim that throughout school he had been told that "he could do better". He was confused as to why, despite considerable effort he had been unable to match his teachers and parental expectations.

Debriefing also allowed Tim the opportunity to discuss the symptoms of general anxiety which had not been addressed either by the Psychiatrist or by the Unit staff. Although Tim's panic disorder had abated following anti-depressant intake, he was naturally concerned about the possibility of relapse and of being unable to cope.

He was also concerned about a longstanding fear of confined spaces in which he perceived escape to be problematic eg toilets with faulty locks, air travel and lifts. More recently, he had experienced panic disorder whilst sleeping overnight in a tent and was now very concerned about an impending camping trip with his friends. He had also recently began to have difficulty with urinating in public toilets. A minor phobia about mushrooms was also evident.

Tim's predilection to worry was demonstrated by recollection of early fears of death and of being separated from his parents. Such thoughts had been a theme in his initial experiences of claustrophobia. For example, he recalled having experienced panic when trapped in a duvet cover at the age of five.

HYPOTHESES:

1: That Tim's Verbal IQ > Performance IQ discrepancy is a reflection of visuo-spatial /visuo-motor difficulties. Such difficulties may be attributed to birth trauma or are a feature of a minority of normal, ie non-brain damaged children (Yule, 1989)

#2: That Tim's WISC III results were significantly influenced by the side-effects of antidepressant medication, visual defect and attention /emotional variables.
(Cepedo, 1989)

Shortly after testing with the WISC III, Tim's anti-depressant medication was withdrawn due to tachycardia. Subsequently he no longer experienced visual difficulties. However, an eyesight test revealed that he does have a minor degree of myopia for which reading glasses were prescribed.

These changes allowed further administration of psychometric testing of cognitive abilities.

#3: That Tim's anxiety is a co-morbidity factor in his major depressive disorder and is related to a fear of relapse of panic disorder. His phobic anxiety is a compounding variable and has been maintained by avoidance and escape behaviours.

HYPOTHESIS TESTING: (Refer Appendix C, page 25)

A. INTELLECTUAL ASSESSMENT: BRITISH ABILITY SCALES (Elliot, 1983)

Subtests of the British Ability Scales (BAS) were chosen to compute an alternative General, Verbal, and Visual IQ's. Correlations with the WISC R for these IQ scores are 0.59, 0.66 and 0.29 respectively. Despite the poor correlation of the latter, the range of Visual IQ subtests available does provide useful comparative data and an objective estimate of visuo-spatial / visuo-motor skills and short-term visual memory. (Thomson 1991)

B. ASSESSMENT OF VISUAL MEMORY

1. BAS subtests: Immediate Visual Recall; Delayed Visual Recall and Recall of Designs.
2. Rivermead Behavioural Memory Test (R.B.M.T.- Wilson et al, 1985)
3. Rey-Osterrieth Complex Figure Test (cited by Spreen and Strauss, 1991)
4. Rey Visual Design Learning Test. (R.V.D.L.T.- Rey, 1964)

C. ASSESSMENT OF AUDITORY VERBAL MEMORY.

1. BAS: Recall of Digits.
2. WISC III (UK) (Digit Span re-test)
3. Rey Auditory Verbal Learning Test. (R.A.V.L.T. cited by Lezak, 1983)

D) ASSESSMENT OF TOPOGRAPHICAL MEMORY.

1. R.B.M.T: Route Task.
2. An ad hoc location of local and national towns test as suggested by Lezak (1983)

E) ASSESSMENT OF ANXIETY.

1. Behavioural Avoidance Tests (Morris and Kratochwill, 1983)

Note: a satisfactory psychometric measure of trait anxiety was not available.

F) SUPPLEMENTARY ASSESSMENT:

- i. - Hostility as a co-morbidity factor (Messer and Gross, 1994) using the State-Trait Anger Expression Inventory (Spielberger, 1988)
- ii. - Self Esteem : Harters self-esteem questionnaire.(Hoare et al 1993)

RESULTS :

A) INTELLECTUAL AND MEMORY ASSESSMENT. (Refer Appendix B, p. 20)

The results of intellectual testing on the BAS confirmed that Tim has a high Verbal IQ (Score 123) His average score for Visual IQ (100) is in keeping with his scoring on Raven's Progressive Matrices, although the latter was administered whilst Tim was taking antidepressant medication. His Full Scale IQ score on the BAS is 107, although this score continues to mask a significant Verbal > Performance discrepancy.

These results suggest that Tim's Performance IQ scores on the WISC III were influenced by the side-effects of anti-depressant medication and other extraneous variables. The results of the BAS Visual IQ subtests suggests that Tim does not have a visuo-motor difficulty per se. This was also suggested later by the results of the Reitan Trail Test .eg Part B score = 27 seconds (mean 40.1 sec, s.d. 25.5.) However non-verbal testing is likely to be influenced by a residual degree of motor learning difficulty. The BAS results also suggest that Tim has

a marked problem in the area of visual graphical memory :-

- a. T Score for Immediate visual recall = 35, 7th centile.
- b. T Score for Delayed Visual Recall = 41, 19th centile.
- c. T Score for Recall of Designs = 34, 6th centile.

The results of the R.B.M.T. revealed that Tim's scores for visual recognition memory were satisfactory. His performance on the route task was however below average and suggests inattention to visual detail or a topographical memory problem.

On the Rey-Osterrieth Complex Figure Test, Tim scored within the average range for the copy test. However his score on delayed recall was only 4 (mean 24.59, standard deviation 6.29). There is of course some controversy as to whether the Complex Figure Test should include an immediate recall test. (Spreen and Strauss, 1991) Administration of the Taylor (1969) version with an immediate recall task confirmed however that Tim performs well below average on this test.

Administration of the Rey Visual Design Learning test demonstrated a score within the normal range and provided some evidence that given sustained attention to detail with repeated learning trials; Tim is able to improve his visual recall on such tests. This may suggest that his difficulty is with the encoding of visual-graphic material.

The assessment of Tim's short-term auditory memory found his scores to be within normal limits with a satisfactory memory for digit and word sequences.

His delayed auditory memory was also satisfactory as shown by the R.B.M.T. subtest of delayed story recall and the R.A.V.L.T. The latter demonstrated a minor degree of proactive interference however.

Tim's performance on the route task of the R.B.M.T. was faulty and his ability to place

local and national towns on a map was poor compared (qualitatively) with 6 male controls of the same school year .

In summarising the above results, it appears to be the case that Tim's has a specific learning difficulty with both the the encoding and retrieval of visual-graphic material. His recognition fo faces and objects is satisfactory as shown by the results of the R.B.M.T. However, his performance on both the route task of the R.B.M.T. and an ad hoc topographical memory task is problematic. The latter suggest a problem with re-visualisation. (Lezak,1983)

Tim's performance on the WISC III was certainly influenced by this difficulty although there is evidence that his low Performance score was also affected by antidepressant medication and emotional variables. Further testing suggests a continuing significant Verbal > Performance/Visual IQ although this discrepancy is less marked than that demonstrated on testing with the WISC III.

6) ANXIETY, ANGER AND SELF-ESTEEM.

Invivo exposure using fear hierachies revealed that Tim's phobic symptoms were triggered by safety and escape cognitions. Central to his fear has been the experience of breathlessness which is compounded by hyperventilation.and cognitions of losing control/social embarrassment.

On the Hartars self-esteem questionnaire, Tim's 'Global' self-esteem and other sub-category scores are above the mean. His score on the 'Scholastic Performance' subscale is however below average, although is within one standard deviation (s.d.).

On the State-Trait Anger Expression Inventory, Tim revealed a Trait anger score which is 1.5 s.d.'s above the mean and an expressed anger score which is 2 s.d.'s

above the mean. These scores are in accordance with Tim's feelings of anger towards his parents for the academic pressure placed upon him. They may also reflect a separation-individuation conflict (Berkovitz, 1981).

FORMULATION.

Tim has been under considerable pressure to achieve in his academic life. His inability to match these expectations has been in part due to an unrecognised specific learning difficulty in the area of visual memory. Tim's depressive condition was triggered by academic and personal identity issues. There may be an endogenous factor. Anxiety and anger are significant co-morbidity factors which require intervention.. His experiences of anxiety and phobic responses are related to a disposition to ruminate about health and safety and his phobic anxieties are maintained by avoidance and escape behaviours. Tim's apparent Trait anger is related to both parental pressure concerning achievement issues and to conflicts concerning separation-individuation.

PSYCHOLOGICAL INTERVENTIONS:

The above formulation suggested the following interventions:

1. Assisting Tim to improve visual recall and the provision of feedback to school via the school's educational psychologist. (Teeter, 1987, Banas and Wills, 1978).
2. Assisting Tim to deal more effectively with general anxiety by initiating anxiety management training. (Ollendick and King, 1992)
3. Assisting Tim to resolve his phobic anxieties through graded exposure.(Morris and Kratochwill, 1983)

4.The provision of feedback to the multi-disciplinary team.

INTERVENTIONS #1to #3.

#1. Strategies were devised in conjunction with the Unit teacher to improve Tim's encoding and recall of visual memory. Feedback was provided to the Educational Psychologist. (Refer Appendix B,p.23-'Remediation')

#2 An educational programme for understanding anxiety was provided. Tim was subsequently asked to keep a diary of his symptoms. Cognitive and behavioural strategies for dealing with anxiety were outlined and rehearsed. A unit nurse trained in relaxation methods agreed to teach Tim relaxation on a daily basis.

#3. A therapist assisted invivo exposure programme was initiated using fear hierachies. Tim was also required to engage in self-directed exposure. His fear of being breathless was tackled directly through 'mini-hyperventilation' exposure (Durham, 1989)

Tim's fear of flying was tackled by generating worry cognitions for both challenging and behavioural exposure through writing/taping. (Salkovskis and Kirk,1989)

It was hypothesised that Tim's anxiety about urinating in public toilets may be resolved indirectly through addressing his fear of toilets. His fear of lifts was deemed to be less problematic and therefore not addressed directly.

RESULTS OF PSYCHOLOGICAL INTERVENTIONS.

#1. Memory strategies: To be reviewed by educational staff.

#2 Anxiety Management training: Tim stated that he had found training insightful and strategies such as challenging anxiogenic thoughts provided him the confidence to deal with

future anxiety. He continues to practice relaxation.

#3 Behavioural exposure:

Figures 1 to 8 :

KEY: Vertical axis:- Subjective anxiety rating (Range 0-10).
 Horizontal axis: A = within-session initial anxiety rating.
 B = within-session final anxiety rating.

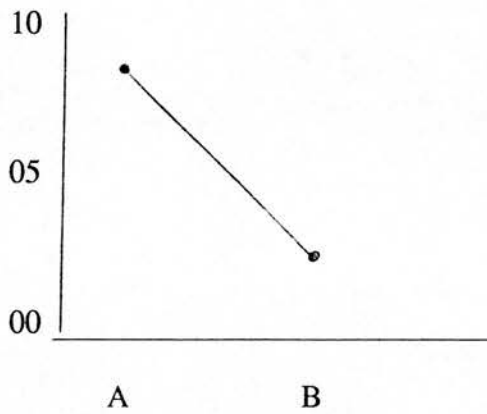


Figure 1: Exposure to toilet X

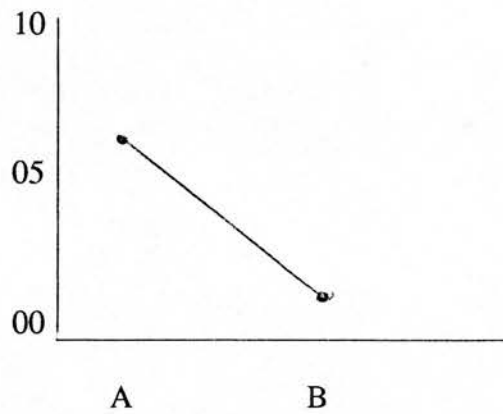


Figure 2: Exposure to toilet Y

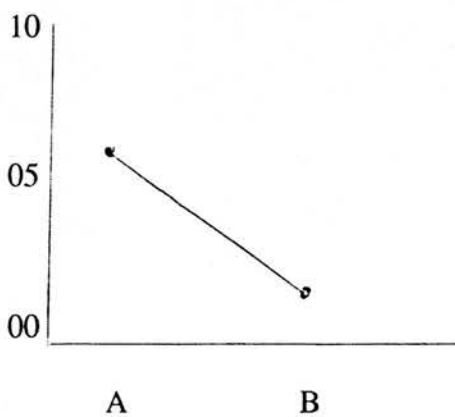


Figure3: Exposure to toilet W

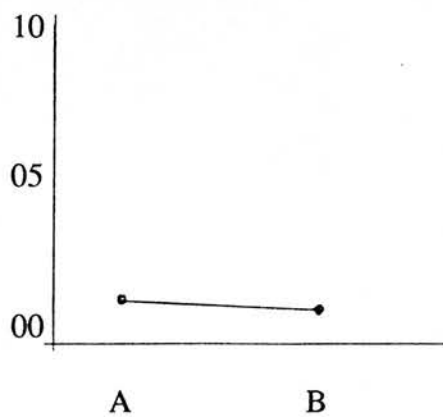


Figure 4: Exposure to toilet Z

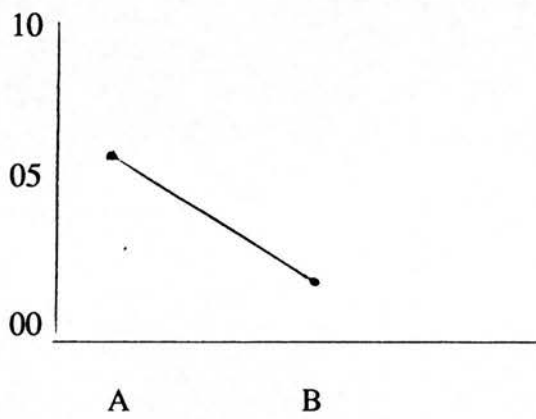


Figure 5: Exposure to sleeping bag
-Head outside

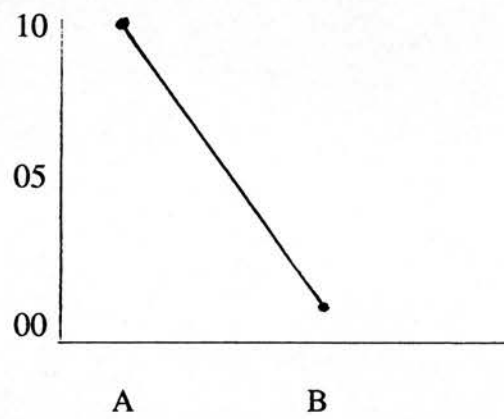


Figure 6: Exposure to sleeping bag
-Head inside

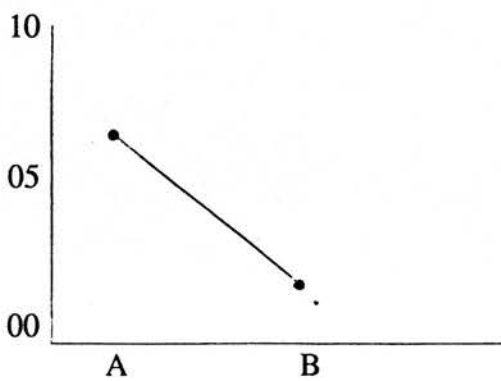


Figure 7: Head at bottom of sleeping bag.

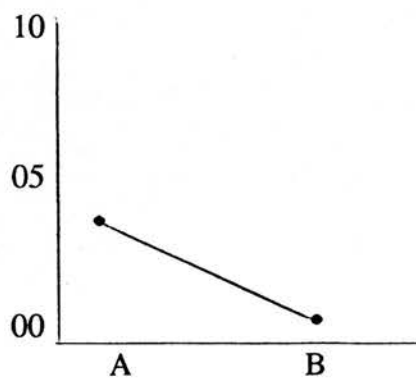


Figure 8: Sleeping bag within tent.

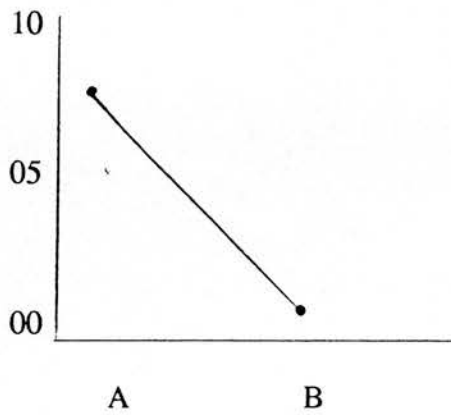
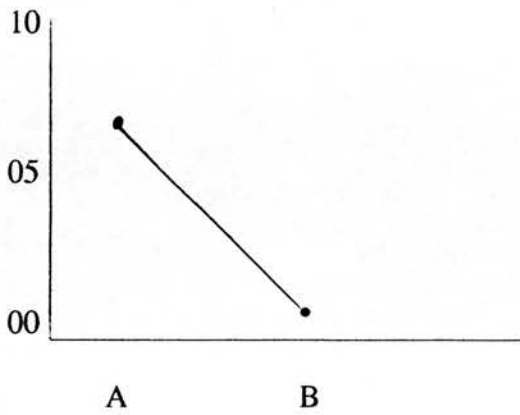


Figure 9: Exposure to sight of mushrooms Figure 10: Exposure to touch

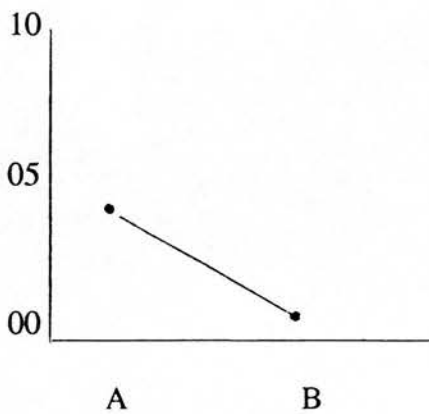
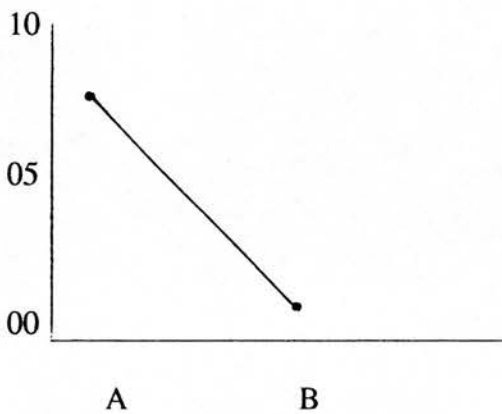


Figure 11: Exposure to sight of mushrooms (large)

Figure 12: Exposure to touch (large)

As the above figures demonstrate, Tim has resolved his fears concerning mushrooms, sleeping bags/tents and of being locked in toilets. He is now less concerned about experiencing breathlessness. It is likely that such effects will generalise to other

situations which he finds problematic ie. air flight and lifts and the possibility of future panic disorder. Tim's fear of urinating in a public toilet requires further intervention however.

SUMMARY:

The results of cognitive assessment reveal that Tim has a marked Verbal IQ > Performance IQ score due to problems with the encoding and retrieval of visual material. He also demonstrates average short-term auditory memory ability. This assessment has allowed both Tim and his parents to consider more reasonable expectations of his academic abilities and remove a major stressor from his current life.

The assessment and interventions for his anxiety condition have proved to be of considerable benefit to Tim. He now reports increased confidence in being able to tolerate future anxiety due both to anxiety management training and by his experience of coping with behavioural exposure. It may be the case that such confidence may have a mediating influence in preventing further episodes of depression.

This case study has demonstrated some of the difficulties inherent in psychometric assessment where psychotropic medication is in use. It also demonstrates the progressive hypothesising nature of Clinical Psychological assessment and intervention. The assessment and interventions were carried out within the context of a multi-disciplinary team with some overlap evident and desirable. Feedback of Clinical Psychological assessment proved to be useful in guiding the clinical and educational input of the other professionals involved with Tim.

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INTELLECTUAL ASSESSMENT.

c/o Unit.
Referred by Dr.

_____ D.O.B.
Chronological age 13-6 years.

WESCHLER INTELLIGENCE SCALE FOR CHILDREN III (UK).

_____ was assessed using the Weschler Intelligence Scale for Children III (U.K.). Assessment was carried out over three sessions in December 1994-

Session 1 (07.12.94) Subtests 1-5.
Session 2 (08.12.94) Subtests 6-9.
Session 3 (15.12.94) Subtests 10-13.

TEST BEHAVIOUR:

_____ appeared anxious and tired throughout session 1 with visual difficulties apparent on administration of the Performance tasks. On subsequent sessions, _____ appeared to be less tired and more relaxed although continued to have apparent visual difficulty with Performance tasks. At the time of testing, _____ was on a regime of anti-depressant medication.

_____ was aware that the test was a measure of IQ and he was concerned throughout testing to achieve a satisfactory performance. He demonstrated a propensity to check his responses for accuracy at the expense of speed.

RESULTS OF ADMINISTRATION OF THE WISC III (UK):

<u>VERBAL SCALE:</u>	Scaled (pop. average = 10) Score
Information	10
Similarities	16
Arithmetic	14
Vocabulary	14
Comprehension	19
(Digit Span)	7

PERFORMANCE SCALE:

Picture Completion	7
Coding	10
Picture Arrangement	6
Block Design	8
Object Assembly	9
(Symbol Search)	5
(Mazes)	10

The above subtest results yield the following IQ scores;

VERBAL I.Q. 128
 PERFORMANCE I.Q. 85

FULL SCALE I.Q. 109 (Population average = 100, S.D. = 15)

This Full Scale I.Q score yields a qualitative level of IQ within the population average range of 90-109. This confirms previous testing by Mrs. _____ (_____ Unit teacher), who found that _____ performed within the average range of ability on the Raven's Progressive Matrices.

IT WOULD BE UNDESIRABLE HOWEVER, TO QUOTE THIS FULL SCALE IQ SCORE AS IT CONCEALS A MARKED DISPARITY BETWEEN _____ VERBAL AND PERFORMANCE IQ'S.

_____ demonstrates a high score for Verbal I.Q. with significant subtest scatter. His Comprehension score is significantly higher above the mean for 5 Verbal subtests. His score on Information (general knowledge) is average for his age group although significantly lower than the mean on 5 Verbal subtests. His score for Digit Span, a test of short-term auditory memory, is also significantly lower than the mean for 6 Verbal subtests. This low score may be due to test anxiety. Digit Span is not computed however for the Verbal IQ Score.

_____ scoring on the Performance subtests does not demonstrate significant scatter and yields a considerably lower Performance IQ than would be expected. The marked discrepancy between Verbal IQ and Performance IQ suggests that _____ may have a learning difficulty related to visuo-spatial/visuo-motor skills. However, his scoring on Performance tasks may also have been impeded by emotional factors and/or visual difficulties.

The WISC III also yields four factor -based index scores which provide further representation of _____ difficulty with Performance tasks:

<u>INDEX SCORES:</u>	<u>SCORE</u>	<u>% RANK</u>
VERBAL COMPREHENSION	127	96
PERCEPTUAL ORGANISATION	83	13
FREEDOM FROM DISTRACTIBILITY	104	61
PROCESSING SPEED	86	18

The below average score for Perceptual Organisation (combining scores on Picture Completion, Picture Arrangement, Block Design and Object Assembly) also suggest that _____ may have a difficulty in the area of visual-spatial processing / motor delay.

His similar score on Processing Speed (combining scores for Coding and Symbol Search) may be a feature of motor delay although the score is skewed by the very low scaled score of 5

for Symbol Search. Processing Speed is also likely to have been effected by _____'s apparent need to achieve accuracy. The average score on Freedom from Distractability suggests that _____ concentration was satisfactory throughout testing.

SUMMARY:

Despite considerable subtest scatter, _____ score on Verbal IQ testing is a reliable indicator of his high verbal intelligence. His Performance IQ Score is within the low average range and suggests a difficulty in the area of visuo-spatial processing/motor-learning. However, his scoring may have been confounded by emotional factors, tiredness, apparent visual difficulties and a propensity to sacrifice speed for accuracy. His Performance IQ score and Full Scale IQ Score should therefore be considered as provisional subject to further testing and an assessment of motor-learning difficulty by the Occupational Therapy Department.

Yours sincerely,

James Isles,
Trainee Clinical Psychologist. _____
Chartered Clinical Psychologist.

10.01.95

distribution:

Dr. _____ Consultant Psychiatrist.
_____: Ward Nursing Staff,
Mrs. _____, Occupational Therapist.

APPENDIX B: Letter to Educational Psychologist.

Dear (Educational Psychologist)

Tim was admitted to theUnit ,.....on 29.9.94 with an affective disorder. His condition has now improved and he is currently attendingAcademy (S2) on a part time basis with a view to full time schooling following the Easter break. I gather that Dr....., Consultant Psychiatrist has liased with yourself concerning Tim's progress at school and his specific learning difficulty in the area of visual memory.

A core feature of Tim's affective disorder has been his anxiety concerning scholastic performance. Dr.....therefore referred Tim to this department in December, 1994 for assessment of his intellectual abilities. Subsequently I administered the WISC III to yield a Verbal IQ Of 128 and a Performance IQ of 85. (Report enclosed).

Such a marked V>P discrepancy indicated a visuo-spatial/visuo-motor difficulty with short-term memory problems. At the time of testing however, Tim was on anti-depressant medication and complained about blurred vision. He also demonstrated considerable test anxiety. He was not considered to be clinically depressed at this time.

Such factors may have influenced his responses on the Performance subtests and I therefore delayed further testing until medication was withdrawn. He has had his eyesight tested to reveal an apparent minor degree of myopia for which he has been prescribed glasses.

Tim was also assessed by an Occupational Therapist in December, 1994 whose report indicates that Tim has a mild motor learning difficulty which manifests as balance problems and residual difficulties with bilateral integration. He also has an unorthodox pencil grasp. Tim's general intelligence and reading ability was assessed by Mrs.....,Unit teacher using Raven's Progressive Matrices and the Neale Analysis of Reading.

Tims's IQ score on the R.P.M. is average and his reading accuracy and comprehension are both age appropriate.

1. ASSESSMENT OF COGNITIVE ABILITY.(BRITISH ABILITY SCALES):

A. SPEED.

Speed of information processing 96th centile T=68

B REASONING.

Matrices 51st centile T=50

Similarities 98th centile T=71

C. SPATIAL IMAGERY

<u>Block design (Level)</u>	50th centile	T=50
<u>Block design (Power)</u>	38th centile	T=47
<u>Rotation of Letter-like Forms</u>	41st centile	T=48
<u>Visualisation of Cubes</u>	67th centile	T=54

D. SHORT-TERM MEMORY

<u>Immediate Visual Recall</u>	07th centile	T=35
<u>Delayed Visual Recall</u>	19th centile	T=41
<u>Recall of Designs</u>	06th centile	T=34
<u>Recall of Digits</u>	50th centile	T=50

E. RETRIEVAL AND APPLICATION OF KNOWLEDGE

<u>Word Definitions</u>	87th centile	T=61
-------------------------	--------------	------

The above subtests of the BAS compute the following IQ Scores:

Verbal IQ	123	(121 - 129 c.b.) - 3 p.r. subtests	94.1 centile.
Visual IQ	100	(96 - 104 c.b.) - 7 subtests	51.3 centile.
General IQ	107	(104 - 111 c.b.) - 10 subtests	69.2 centile

The above results confirm Tim's high Verbal IQ score and demonstrate that he is performing within the average range on Performance IQ equivalent testing. Thus his low average scoring on the WISC III Performance IQ may have been due to the factors previously mentioned. However, Tim's scoring on the BAS also reveals a marked discrepancy between Verbal IQ and Visual IQ and his scores for the Short-Term Memory subtests are indicative of a visual memory deficit.

2. ASSESSMENT OF MEMORY:

A) SHORT-TERM VISUAL MEMORY.

- i. BAS Immediate Visual Recall as above
- ii. BAS Delayed Visual Recall as above
- iii. BAS Recall of Designs as above
- iv. Rivermead Behavioural Memory Test (Adult) - Face and Picture
recognition both satisfactory.
- v. Rey-Osterrieth Complex Figure Test:

Figure 1. Copy task score = 30.5 (mean = 32.63, s.d. 4.35)

Delayed recall = 4 (mean = 24.59, s.d. 6.29)

This test also reveals that Tim copies designs using piecemeal strategies rather than gestalt approaches.

- vi. Rey Visual Design Learning Test (RDVLT)

Total recalled = 44 (mean = 43.8, s.d. 6.9)

Recognition score = 15 (mean = 13.8)

B). SHORT-TERM AUDITORY VERBAL MEMORY:

- i. BAS Recall of digits 50th centile T=50
- ii. WISC III (UK)- Digit Span (repeated) = Scaled Score 10 (average)
- iii. Rey Auditory Verbal Learning Test:

Total recall, trials A1 - A5 = 53 (mean = 53 s.d. 7.5)

Recognition score = 15 (mean = 14.3 s.d. 1.1)

Delayed recall - satisfactory.

- iv. RBMT Immediate and Delayed Recall of Prose; both satisfactory.

C) EVERYDAY MEMORY:

- i. RBMT Standardised Profile Score = 21 mean = 22.04 (1.97 s.d.)
- ii. RBMT Screening Score = 9 mean = 10.59 (1.37 s.d.)

Assessment of Tim's memory using the above tests confirms that he has a short-term memory deficit in the visual recall domain with a relatively poor performance on both the BAS visual recall tests and the Rey-Osterreith Complex Figures. However, his visual recognition is satisfactory and his performance on the Rey Visual Design Learning Tests suggests that attention to detail can yield a satisfactory learning curve.

Tim's Screening score on the Rivermead Behavioural Memory Test, a test of everyday memory is in the range for poor memory although the score does not demonstrate impairment. His scoring deficit occurred in the recall of route task, confirming a propensity to fail to encode visual detail. An ad hoc test of topographical memory involving the placement of towns on both a local and national map demonstrated that Tim may have difficulties in this domain. His difficulty with the recall of spatial relations is also manifested in poor recall of geographic maps.

Assessment of Tim's short-term auditory verbal memory demonstrates that he has a satisfactory memory for digits, words and digit/word sequencing. A minor degree of proactive interference was evident on the Rey Auditory Verbal Learning Test. There was no evidence however of retroactive interference.

Finally throughout testing, Tim's performance appears to have been influenced by motivational factors such as the propensity to sacrifice speed for accuracy, his poor graphic skills and considerable test anxiety.

C. REMEDIATION:

I have liaised with Tim's teacher at theUnit, Mrs.....with a view to seeking strategies for remediation of Tim's poor attention to visual detail. The following strategies have been suggested to Tim:

1. Rehearsal of scanning activities to improve attention to visual detail.(The use of visual memory games).
2. Encoding visual learning material in the auditory domain - naming the visual element or embedding within a narrative and vocalising softly.
3. Encoding maps and other related visual material using a digital referencing ~~fmt~~

4. Rehearsal of visuo-analytical and constructional abilities by using puzzles and spatial-visual tasks.

5. The adoption of gestalt - details - gestalt approaches to visual learning.

Please contact myself or my supervisor, should you wish to comment on any aspect of Tim's assessment and the above suggested remedial strategies. I will continue to meet with Tim over the next few months to assist him in managing his anxiety symptoms and this will include developing strategies for dealing with test anxiety.

Yours sincerely,

Jim Isles,
Trainee Clinical Psychologist. Chartered Clinical Psychologist.

APPENDIX C - DESCRIPTION OF PSYCHOMETRIC MEASURES.

BRITISH ABILITY SCALES (BAS)

Author: C.D. Elliot (1983)

The BAS is a battery of 23 standardised tests for the assessment of cognitive ability in children ranged 2.5 to 17 years. The BAS measures five processes:-reasoning, spatial-imagery, perceptual matching, short-term memory, and the retrieval and application of knowledge. Speed of information processing is an additional measure.

Specific subtests are computed to derive IQ scores for Verbal IQ, Visual IQ and General IQ.

Correlations of these IQ scores with the WISC(R) are 0.66, 0.25 and 0.59 respectively.

The following BAS subtests were used in this case study:

A. Speed:

To measure speed of information processing:- subject is required to cross out rows of numbers under timed conditions.

B. Reasoning:

1. Matrices:- subject is required to draw / match a pattern from a booklet of patterns.
2. Similarities:- subject is required to link relationship between words verbally. Equivalent to the 'similarities' subtest of the WISC III.

C. Spatial-imagery:

1. Block design:- similar to the 'Block design' test of the WISC III with additional bonuses

awarded for timing.

2. Rotation of letter like forms:- subject required to match a letter like shape from different perspectives.
3. Visualisation of cubes:- subject required to choose a picture depicting a cube face viewed from differing perspectives.

D. Short-term memory:

1. Immediate visual recall:- subject required to recall verbally, the names of objects shown on a card for limited time period.
2. The above task carried out after 20-30 minutes delay.
3. Recall of designs:- subject recalled to draw designs previously shown on a card.
4. Recall of digits:- similar to Digit span of WISC III.

E. Retrieval and application of knowledge:

1. Word definitions:- a vocabulary scale similar to the 'Vocabulary' scale on the WISC III

HARTER'S SELF ESTEEM QUESTIONNAIRE - R.

Revised edition - Hoare et al (1993)

This standardised self-report questionnaire provides the following 6 subscales related to self-esteem -

Global self-esteem, Scholastic Performance, Social Acceptance, Athletic Competence.

Physical Appearance and Behaviour.

Norms are provided for each subscale by Hoare et al (1993) for a Scottish sample of school children aged 8 -15 years.

REITAN TRAIL MAKING TEST - CHILDREN'S VERSION.

Author - Reitan (1986)

Parts A and B of this standardised test of visuo-spatial/motor skills requires the subject to draw lines between numbered/lettered circles under timed conditions. Norms are given for a control group of children 9-14 years compared with brain-damaged children.

REY-OSTERRIETH COMPLEX FIGURE TEST:

Author- Rey (1941)

This test of visuo-spatial constructional ability and visual memory requires the subject to copy and then recall graphically from memory a complex geometrical design. Presentation may be immediate and delayed or delayed only (Spreen and Strauss, 1991). An alternative version and scoring for the complex figure task is provided by Taylor (1969). Norms for Canadian school children aged 6-15 years are provided by Kolb and Wishaw (1985) and are reproduced in Spreen and Strauss (1991).

REY AUDITORY VERBAL LEARNING TEST:

Author- Rey (1964)

This test of verbal learning and memory requires the subject to recall a list of words presented orally during five consecutive trials. An interference list is also given and delayed recall for the original list measured after 20 minutes. An alternative list is provided by Crawford et al, (1989) and reproduced in Spreen and Strauss (1989). Norms are provided for adolescents aged 13-16 years.

REY VISUAL DESIGN LEARNING TEST:

Author- Rey (1964)

This test of nonverbal learning and memory involves the brief presentation of designs which the subject is required to reproduce from memory. Five learning trials are provided and norms are available for Swiss school children aged 9-15 years.

RIVERMEAD BEHAVIOURAL MEMORY TEST.

Authors - Wilson et al (1985)

This standardised memory test attempts to measure analogues of everyday memory. The adult version was used in this case study since it provides norms for an adolescent population. The test has four alternative presentations for repeat testing.

The battery consists of the following subtests:-

1. Delayed recall of the name of a person with portrait prompt.
2. Delayed recall of the whereabouts of a concealed item.
3. Delayed recall of a message.
4. Delayed recall of object recognition form cards presented.
5. Delayed recall of faces from cards presented.
6. Immediate and delayed recall of a route demonstrated within the test room. This test also includes a message task.
7. Immediate and delayed recall of a story told verbally.

STAIT-TRAIT ANGER EXPRESSION INVENTORY-R.

Author - Spielberger, C.D. (1988)

This standardised self-report questionnaire measures the expression of anger on the following scales - State Anger, Trait Anger (with 2 subscales - Angry Temperament and Angry Reaction, Anger-In, Anger-Out, Anger control and Anger expression. The latter subscale combines anger in, anger out and anger control for research purposes.

Norms(adolescent) are provided for State, Trait, Angry Temperament and Angry Reaction based upon an American adolescent population(12-18 years).

WESCHLER INTELLIGENCE SCALE FOR CHILDREN III (UK) - Refer WISC III Manual

TITLE: THE PHENOMENOLOGY OF ANOREXIA NERVOSA:
A SINGLE-CASE STUDY.

JAMES I. ISLES

Submitted in part fulfilment of the degree of doctorate in Clinical Psychology
at the University of Edinburgh, February 2000

I certify that this report is a fair and accurate account of the work carried out.

Signed:

HELEN BURR

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TITLE: The phenomenology of anorexia nervosa: a single-case study.

INTRODUCTION:

Anorexia nervosa is a severe psychiatric disorder with an increasing incidence (Lucas et al, 1991) and varied outcome. Only 20% of those with anorexia nervosa are thought to make a full recovery (Fairburn, 1994) and astonishingly, death rates range from 15% to 20%. (Ratnasuriya et al, 1991). Clinical evidence suggests that there are distinct psychological processes involved in anorexia - for example, issues of achievement and control (Garner and Garfinkel, 1985). However, there is little research evidence to confirm such empirical observations. Further, treatment outcome is variable and similarly under-researched. (Fairburn, 1994). The case study approach therefore is an important source of information concerning the possible underpinnings of this serious psychiatric disorder. This study explores the onset and maintenance factors involved in one person's experience of anorexia nervosa.

THE CLIENT:

Pat is a 24 year old single woman who is currently undergoing weight restoration as an inpatient. She has a seven year history of anorexia nervosa with restrictive food intake and exercise as weight control strategies. Her weight of 35.4 kgs. yields a Body Mass Index of 15, reflecting an emaciated state. There is now radiological evidence of pathological bone density change. Approximately 6 years ago, Pat experienced in-patient treatment at the same hospital, when she restored her weight from 27 kgs to 33 kgs. At that time she had undergone a strict behavioural regime and experienced both individual and group psychotherapy. Unfortunately, she had found disclosure difficult and the strict behavioural regime abusive. Her eventual weight increase was therefore a means by which she could achieve discharge. In this episode, Pat's in-patient treatment was informal and non-aversive. She was required to reduce her exercise level to 1 hour per day and increase her weight by 1 to 2 kg. per week. The psychiatric team were to offer supportive psychotherapy in conjunction with nutritional counselling from a dietician.

PSYCHOLOGICAL ASSESSMENT:

The author, a trainee clinical psychologist had observed Pat's admission and subsequently approached both Pat and her psychiatrist to seek permission to observe the in-patient treatment of anorexia nervosa. The authors intention was to gain clinical experience and insight into the phenomenology of the disorder. Subsequently, the author and Pat met regularly over a

period of 12 weeks to generate shared hypotheses and a formulation of her eating disorder.

ASSESSMENT MEASURES:

Self report questionnaires:

1. Eating disorder: - Eating Disorder Inventory 2 (EDI-2), Body Shape Questionnaire.
 2. Emotions: - Foulds and Bedford Scales - Neurotic Symptoms. Hospital Anxiety and Depression Scale (HAD), Beck Hopelessness Scale (BHS), State-Trait Anxiety Inventory, State-Trait Anger Expression Inventory (STAXI), Rosenberg Self-Esteem Scale.
 3. Family dysfunction - McMasters Family Assessment Device.
 4. Health control - Health Locus of Control Scales (HLCS).
- (Refer Appendix)

Qualitative measures:

1. A grounded theory approach following Glaser and Strauss (1967) was adopted within a hermeneutic research paradigm (Shotter, 1974)
2. The metaphor of child-within / subpersonality was used as a model in understanding the meaning of self-identity and associated action. (Rowan, 1990)

Therapeutic alliance:

It is recognised that individuals who suffer from anorexia are often ambivalent about weight restoration . The failure to gain

weight by way of various ploys may provoke feelings of frustration in those involved in care (Kalucy et al, 1985; Treasure et al, 1995). However, as Treasure et al (1995) suggest, compliance problems should be an expectation of treatment which should be accounted for, rather than viewed as merely sabotage. In this study, the therapeutic relationship was facilitated by the authors lack of involvement in treatment issues and perhaps the naive position adopted by Bruch (1973) of "a fact finding, non-interpretive approach" (p56).

RESULTS OF PSYCHOLOGICAL ASSESSMENT:

Pat views herself as a vulnerable individual, who has since early teens felt uneasy with groups of people due to her experience of bullying. On a one to one basis she presents as a friendly, humourous character without apparent social anxiety. In a group situation however, she experiences mild anxiety and concerns that she may be exposed to criticism. Her natural desire to shrink away from conflict is reflected symbolically in her shrinking body image. Her anxiety is also reflected on the State-Trait Anxiety Inventory at 80 and 82 percentile respectively (Spielberger, 1983).

Pat's concerns about her weight are two-fold. Firstly if her bone density does not improve, she may suffer spinal injury and be required to give up exercise and sports. Secondly, as a university student she is concerned that her anorexia may also have resulted in cognitive impairment and thus impede her academic objective of obtaining a first class degree. However, Pat's motivation to increase weight is hampered by fundamental

fears about the prospect of giving up her eating disorder, which has served her well in terms of self-achievement. She has managed to achieve slimness and deny hunger. Her control over her food is unequivocal and her social identity as a 'slim person' assured. Her fragility also serves to suggest vulnerability with subsequent gains in being cared for and in avoiding social rejection. She does not advertise her eating disorder however, and eschews the label of anorexia which she feels is stereotypical and thus robs her of an unique self-identity. Her self-esteem on the Rosenberg scale is low.

Pat's scoring on the EDI-2, suggests both ineffectiveness and ascetism. The former subscale measures insecurity and lack of control in life and is regarded as one of the fundamental underpinnings of anorexia (Bruch, 1962 , Crisp, 1980, Garner, 1991). In contrast, on the Health Locus of Control Scales, Pat demonstrates a high level of perceived internal control over her health, with low average scores on the external control dimensions of Chance and Powerful Others. (Wallston et al, 1978). On the ascetic subscale of the EDI-2, Pat scores at the high end of an anorexic comparison group suggesting the pursuit of self-denial and restraint (Garner 1991).

BODY IMAGE:

Pat's EDI -2 scores place her within the anorexic comparison group on the 'Drive for Thinness' dimension; although her body dissatisfaction is typically sub-clinical on the EDI and only moderate on the Body Shape Questionnaire.

On initial discussion of her body image, Pat reflected -

/ "I can't see what the problem is..... my body is OK.....in fact, I think my legs are pretty good".

However when confronted with a mirror image, she became tearful and acknowledged the thinness of her arms and the disproportion of her body schema. More importantly perhaps, she felt embarrassed by the author's presence due to her awareness of feeling ugly - a feeling which stems from her experience of school bullying. Pat also acknowledges that being thin serves to reduce sexual interest from men and therefore potential criticism about her looks. This issue appears to be defensive rather than related to Crisp's (1980) maturity-fear hypothesis.

CO-MORBIDITY:

Depression and obsessive-compulsive disorder are common co-morbidity problems in anorexia nervosa. (Thompson, 1993). In this case co-morbidity was not established on clinical presentation and self-report measures. On the Beck Hopelessness Scale, Pat scored at a moderate level however, thus reflecting realistic concerns about her future. Her scoring on the Stait-Trait Anger Expression Inventory suggested a very low Trait Anger, combined with a high level of suppressed anger (Spielberger, 1979).

PSYCHOSOCIAL AND FAMILY ENVIRONMENT:

Pat moved away from home to attend university where she had her own flat. At university she had a network of friends with whom she shared sporting and social activities. A propensity however,

to study for long hours and to avoid social eating has limited her social interaction. Having temporarily given up university to seek help for her anorexia, she is now living at home and is somewhat more isolated and dependent upon her family.

Pat describes her mother as domineering and admits to strong feelings of frustration when her mother offers advice on how to resolve the anorexic problem. However, she does not perceive a strong link between her mother's controlling behaviours and her own pursuit of control. Her scores on the McMasters Family Assessment Device, also fails to support such a link and she has always felt loved and cared for by her parents. However, Pat acknowledges that there are unresolved issues concerning her relationship with her mother, particularly in her anorexic identity which enjoys feeling cared for. She also expresses feelings of loss concerning her relationship with her father, who appears to be a background figure in her life.

On reflecting upon her early childhood, Pat recalls being generally a happy child although is aware of memories of extreme shyness in social settings. On reflecting upon her later childhood however, her memories are more troublesome as revealed in the scenarios described below.

HYPOTHESES:

1. That Pat's anorexia is maintained by achievement and control issues central to her self and social identity.
2. That her anorexia stems from social identity issues in childhood and the containment of emotion.

CHILD-WITHIN MODEL: RESULTS.

The child-within/subpersonality model of self is a simplistic model which may be both consumer friendly and therapeutically powerful. The model derives from both psychodynamic and humanistic psychology although may easily be incorporated within contemporary cognitive accounts of selfhood. For example, self-schemata (Markus and Sentis, 1982); small minds (Ornstein, 1986) and neural networks (Rumelhart and McClelland, 1987; Li and Speigel, 1992; Casper et al. 1992). The child-within model is essentially a dynamic and flexible representation of self. It generates explanations for heuristic responses to new and threatening environments, where the lack of domain-specific schemata leads to social failure. It therefore has much in common with a mental models approach to psychological problems (Power and Champion, 1986).

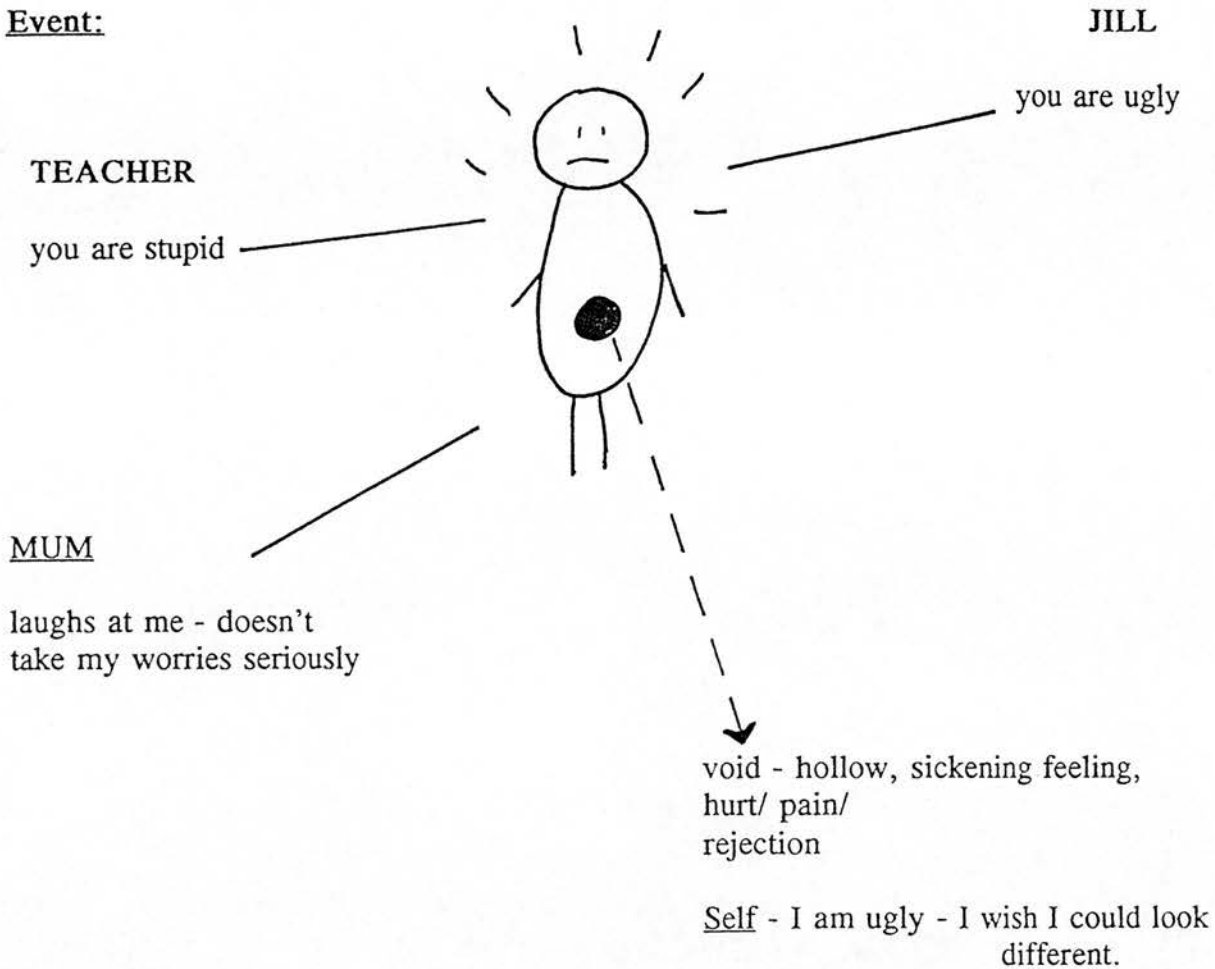
In Pat's case, the model is a useful metaphor in helping her understand the apparent dichotomy between her desire both to restore weight and to maintain a sense of self-efficacy through restrictive eating. Using drawings, progressive hypothesising and minimal induction hypnosis, the following developmental sequences and subpersonality formation were constructed-

LITTLE PAT - SECONDARY SCHOOL:

Figure 1 illustrates some of the early processes involved in Pat's adoption of emotional containment:-

figure 1

LITTLE PAT - SECONDARY SCHOOL

Event:Response:

Hurt - cry (alone) ---> void diminishes slightly
EMOTIONAL CONTAINMENT
Anger - I do not have the right to feel angry
EMOTIONAL CONTAINMENT

Coping:

I can't tell Mum - she will only tell me what
"I should do" - she will say just ignore them.
EMOTIONAL CONTAINMENT - CONTROL

I will be best (I will show them)

Action:

ACHIEVEMENT at sport ----> picked for their team
----> void diminishes

In her early teens, Pat's face was apparently plump (confirmed by a photograph). She recalls that whilst in class, a fellow pupil (Jill) suddenly turned to her and called her ugly.

Subsequently Pat was teased about her face by this girl and others with considerable distress experienced. She recalls having told her mother that she wished to have plastic surgery because she was being teased. Her mother dismissed Pat's concerns and typically advised Pat to be more assertive. Unfortunately Pat could not be assertive with Jill and her friends and she more and more desired to be part of Jill's group -

"I wanted to be one of them....when I was with my friends I could see Jill across the playground....and wanted to be over there ..so that I could be part of them ..be accepted."

Using minimal induction hypnosis the author assisted Pat to recall the emotional content of these memories. She subsequently recalled her emotional experience as a horrible void in her abdomen. Unable to disclose to her parents for fear of mother's unhelpful responses, she cried alone in her bedroom. Eventually, as so many children have done in the face of deep emotional pain, Pat adopted the process of emotional containment. (Miller, 1990, Herman, 1992). In the phenomenology of anorexia such containment has been recognised since Lasegue (1873). More recently, Casper (1983) posits that an unstable self-concept may lead to the adoption of thinness to regulate unwanted emotions and enhance self-esteem and autonomy. In a subpersonality / child-within model, the regulation of emotion may be described as the

predominance of a protective, dominant self who prevents further distress through emotional containment and dissociation from pain. (The concept is equivalent to Bion's (1962) 'container'). Thus the hurt self, the 'inner child' is cosetted behind a protective shell or persona and may exist - needs unmet into adulthood. Pat's strong, protective self also resolved to be 'good at something' and indeed she achieved this objective and subsequent social acceptance through sport -

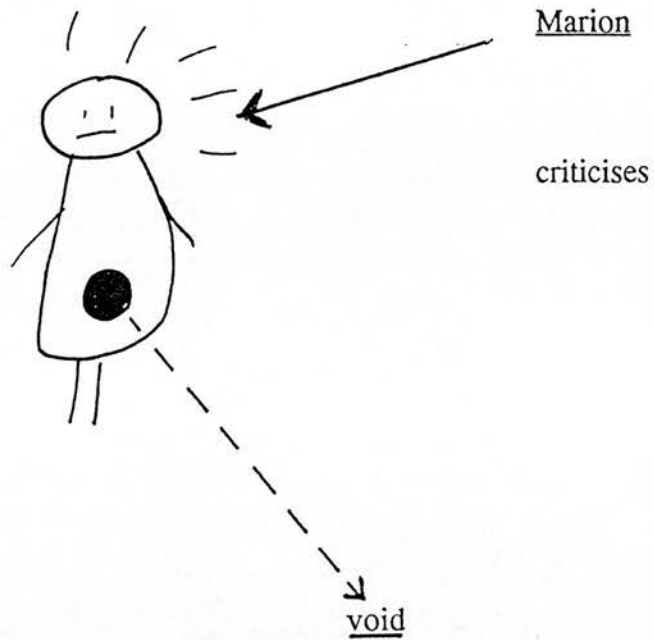
"They would pick me for the game because I was good at it ...that made me feel accepted ...I strove to be better than them...to be the best.....yes the void diminished".

At this point in her life, Pat did not achieve academically. The emotional turmoil of social rejection and later the pursuit of physical achievement interfered with learning. Further, the image of being embarrassed in front of her class by a teacher is embedded in her consciousness. She recalls the words "you are stupid girl" as both humiliating and compounding her already fragile social identity. It was not until recently, that Pat discovered that she could also achieve through academic performance.

(2) OFFICE PAT.

Figure 2 illustrates the events and processes which led to the development of an anorexic identity.

figure 2 -

PAT - OFFICE JUNIOR

Feelings: rejected/ not accepted/
discomfort/ stupid/ ugly

Response:

Hurt -----> void (bottled up emotion)
CONTAINMENT

Coping:

Can't achieve

Action:

- Shrinkage - I'm not OK
- they're dieting - I need to be like them
- I can do it better than them (diet)

Result:

- they talk to me when I don't eat
- I can tolerate the void - it makes hunger easy
- The more I shrink - the more attention that I gain
- I feel OK

At 17 Pat left school to work in an office. Marion, a domineering colleague (in many ways like Pat's mother) was to criticise Pat for work errors and her choice of clothing. Pat thus began to experience old feelings of social rejection and humiliation. Unable to be assertive or express anger, Pat adopted a 'laying low' approach which she describes as shrinkage. Her real shrinkage through anorexia followed inadvertantly. Dieting was the office norm and although Pat did not feel the need to diet - she discovered that dieting was also a social script which generated relationships -

"When they came into they canteen I felt so anxious - the emotion swelled up in me and took away my hunger....they noticed that I wasn't eating and commentedI felt noticed and accepted."

"Losing weight was easy....I tolerated hunger so well...it was a way of achieving something and being liked...they would ask how I had managed to lose so much weight."

Pat's anorexia therefore began within the context of the development of social identity in a threatening environment. At school Pat had developed a sporting identity to seek acceptance. In the office, such an identity was not relevant. The adoption of a new social identity - an anorexic identity was highly relevant and socially desirable. It was also a means by which she could express anger -

"I could diet better than they could.."

(3) ANOREXIC PAT:

Figure 3. illustrates Pat's current self-identity and the maintaining factors in her eating disorder.

figure 3

ANOREXIC PAT

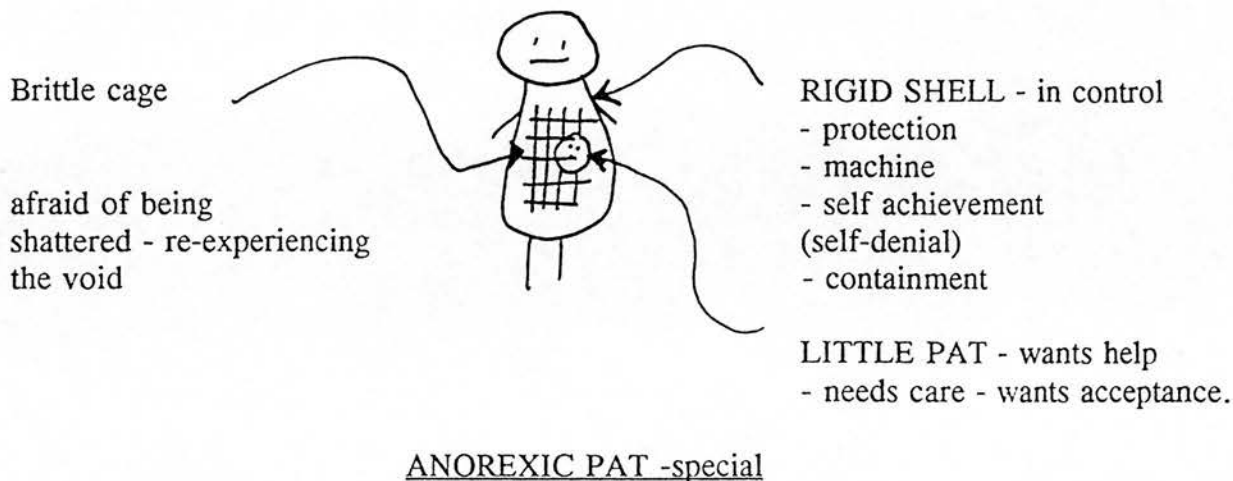
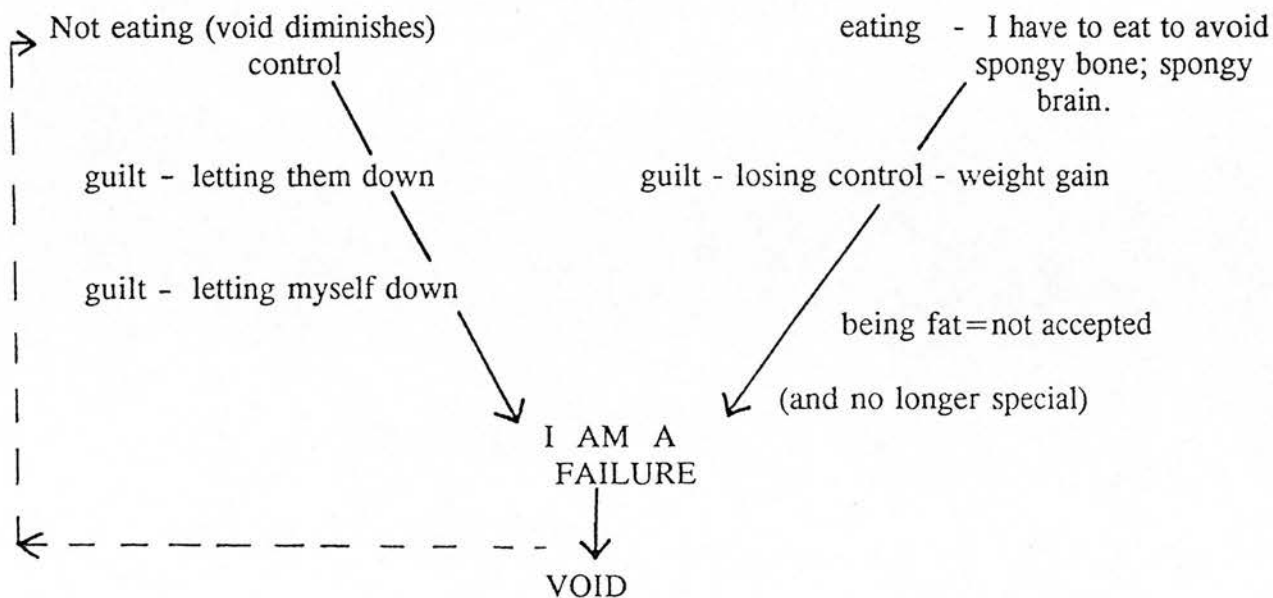


figure 4.

CONFLICT - INPATIENT TREATMENT.

CONTROL ISSUE:

1. Too scared to let go
2. I will lose my special identity if I let go
3. If I let go this time - its for good - that's scary

Her 'rigid shell' is a controlling subpersonality - a machine which directs her food intake and ensures minimal weight gain through dieting and exercise. This strong outer self protects Pat from potential criticism and rejection. (In psychodynamic terms this part may also be viewed as an internalisation of her mother's dominance or perhaps the idealised protective father figure).

It is the controller who "shuts down when I panic about food or people ". The controller cannot 'give up' control unless it is safe to do so. In the anorexic state however, there may be no safety - the identity is too fragile for complacency.

Little Pat is the 'inner child'- the part that occasionally yearns for food and escape - to be free of the restrictions of dieting and weight control. However Little Pat is frightened that the brittle cage of protection may shatter leading to both exposure and to loss of control. Such a loss, she feels would lead to possible binge-eating, fatness and hence exposure to criticism. Little Pat needs to be accepted by others and also needs to feel cared for - she is emotionally, at an early level of development.

Little Pat "runs around trying to please everyone - I suppose to stop them from hurting me".

Anorexic Pat is thus a 'working' identity which serves to provide protection and care. It is constantly being defined in terms of self and social identity (Shotter, 1984). The anorexic identity serves to give Pat a sense of being special -

" I suppose that if I was fat, I would no longer be special".

Pat's conflicts about weight restoration are also illustrated in Figure 4 above. Her desire to please the staff and her need to avoid further physical damage is impeded by the guilt which she believes will follow weight restoration. Guilt also stems from the failure to increase weight and thus please significant others. The conflict is circular and the result failure.

The above scenarios are used to illustrate the difficulties which Pat has in restoring her weight to a reasonable level. The staff involved in Pat's treatment appear to be perplexed and frustrated by her inability to increase her dietary intake. Such perplexity stems from beliefs about absolute agency in human nature and the issue of choice. A child-within model of anorexia does not generate such perplexity. Rather, the model allows for confusion and conflict between acknowledged parts and thus the multiplicity of human identity. The resolution of conflict between parts of the psyche is the underlying premise in psychotherapy. It is reasonable therefore to conclude that in this case, Pat's symptomatology will persist until such conflict is at least partially resolved.

By the end of the author's contact with Pat, she had gained considerable insight into the underpinnings of her eating disorder. What effect this insight has had on her behaviour is not yet clear. The process of hypothesis generation and formulation may have simply been an intellectual exercise for her, with little impact on her need to control her eating. However, she now feels that the two major parts of self described

above - the hurt child and the protective controller, have began to fuse together. Such symbolic fusion may be an early indicator that Pat is on the first steps towards shedding her anorexic identity.

FURTHER PSYCHOLOGICAL ASSESSMENT:

There are aspects of Pat's life which require further exploration in providing a fuller psychological assessment of the underpinnings of her anorexia. For example, the origins of guilt as a response to anger are not clear. One hypothesis to explore with Pat, is the view that her mother's pervasive dominance has generated considerable anger in Pat's life and which during childhood, would have been required to be contained. A further area worthy of exploration, is Pat's feelings about her father and the possibility of an unresolved loss issue. Both issues may be embedded within a separation-individuation hypothesis (Bruch, 1973)

Pat's concerns about her "spongy brain" contrast with her apparent academic performance. However, there is increasing evidence of mild cognitive impairment in anorexia (Treasure and Szukler, 1995) and it would be appropriate therefore to assess Pat's cognitive functioning.

RESULTS OF INPATIENT TREATMENT:

The necessity for in-patient treatment of anorexia is generally based upon clear clinical and psychiatric criteria. For example, Treasure et al (1995) delineate factors such as a body mass index below 13.5, acute medical pathology, a risk of suicide, extreme

social isolation and failure of out-patient treatment.

Pat's condition did not meet such criteria, although her low B.M.I and pathological bone density do require to be addressed. Her admission however, to a busy psychiatric ward was from the outset contentious. At 11 weeks post admission, Pat's weight had only increased by 1.5kg and following a review, the multidisciplinary team have decided to prepare her for discharge. The majority of those involved with Pat believed that she is insufficiently motivated to increase her weight. Indeed, some staff expressed suspicion that she had offset her reduction in exercise time by increased energy expenditure. Pat however feels that she has attempted to change by trying new foods, by following her dietary plan and by preparing herself for change. She feels both upset at failure and angry at being expected to do too much, too soon-

"what do they expect, I' ve been like this for seven years..how can I give it up so soon".

Pat will not be abandoned however and the author has recommended that she be offered individual therapy as an outpatient to continue to explore the issues raised in this assessment. Cognitive-behavioural interventions may also have a role in addressing Pat's anxiety symptoms, related both to social interaction and to the control of eating. Pat is not keen to have group therapy which she envisages to be too threatening for her at this stage. Neither does she feel that family therapy would be a useful approach. Given the compliance problems evident in the treatment of anorexia, it is important that attempts are made to match Pat's needs. (Crisp et al, 1991).

FORMULATION:

Pat's anorexia is maintained by the need to defend herself from social rejection and associated emotional pain. The maintenance of a low weight generates feelings of control and thus achievement. Low weight also serves to generate feelings of care in others. Anorexia thus provides Pat with a unique self and social identity. This identity appears to have been precipitated by a threatening social environment. The origins of her poor social identity however, stem from her experience of school bullying, the subsequent adoption of emotional containment and the pursuit of a social identity through achievement. Underlying issues of low self-esteem, suppressed anger and vulnerability may have their roots in earlier childhood experiences and family background. The latter dimensions require further investigation.

SUMMARY:

This case study is an attempt to describe the phenomenology of anorexia nervosa. In doing so, the empirically derived observations of control and achievement issues have been validated. In this study, distorted body image does not play a major a role in maintaining anorexia. The drive for thinness apparent in Pat's presentation is a drive for both ascetic reasons and to promote vulnerability. Her body image is thus functional rather than distorted as defined by Bruch (1962). The major psychological issue underpinning Pat's anorexia appears to be the process of establishment of a unique self-identity within the context of a fragile social being. Her inability to "give up" her eating disorder reflects underlying conflicts

related to self and social identity and may not be resolved unless engaged in meaningful psychotherapy.

Word length, 3,500 exc. references.

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APPENDIX - ASSESSMENT QUESTIONNAIRES.

2 ITEM BOOKLET

David M. Garner, Ph.D.

DIRECTIONS

Enter your name, the date, your age, sex, marital status, and occupation. Complete the questions on the rest of this page. Then turn to the inside of the booklet and carefully follow the instructions.

Name _____ Date _____

*Age _____ Sex _____ Marital status _____ Occupation _____

A. *Current weight: _____ pounds

B. *Height: _____ feet _____ inches

C. Highest past weight excluding pregnancy: _____ pounds

How long ago did you first reach this weight? _____ months

How long did you weigh this weight? _____ months

D. *Lowest weight as an adult: _____ pounds

How long ago did you first reach this weight? _____ months

How long did you weigh this weight? _____ months

E. What weight have you been at for the longest period of time? _____ pounds

At what age did you first reach this weight? _____ years old

F. If your weight has changed a lot over the years, is there a weight that you keep coming back to when you are not dieting? ____ Yes ____ No

If yes, what is this weight? _____ pounds

At what age did you first reach this weight? _____ years old

G. What is the most weight you have ever lost? _____ pounds

Did you lose this weight on purpose? ____ Yes ____ No

What weight did you lose to? _____ pounds

At what age did you reach this weight? _____ years old

H. What do you think your weight would be if you did not consciously try to control your weight? _____ pounds

I. How much would you like to weigh? _____ pounds

J. Age at which weight problems began (if any): _____ years old

K. Father's occupation: _____

L. Mother's occupation: _____

PAR Psychological Assessment Resources, Inc.
P.O. Box 998 / Odessa, Florida 33556 / Telephone (813) 968-3003

INSTRUCTIONS

First, write your name and the date on your EDI-2 Answer Sheet. Your ratings on the items below will be made on the EDI-2 Answer Sheet. The items ask about your attitudes, feelings, and behavior. Some of the items relate to food or eating. Other items ask about your feelings about yourself.

For each item, decide if the item is true about you ALWAYS (A), USUALLY (U), OFTEN (O), SOMETIMES (S), RARELY (R), or NEVER (N). Circle the letter that corresponds to your rating on the EDI-2 Answer Sheet. For example, if your rating for an item is OFTEN, you would circle the O for that item on the Answer Sheet.

Respond to all of the items, making sure that you circle the letter for the rating that is true about you. DO NOT ERASE! If you need to change an answer, make an "X" through the incorrect letter and then circle the correct one.

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.
27. I feel inadequate.
28. I have gone on eating binges where I felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.

38. I think about bingeing (overeating).
39. I feel happy that I am not a child anymore.
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards.
43. My parents have expected excellence of me.
44. I worry that my feelings will get out of control.
45. I think my hips are too big.
46. I eat moderately in front of others and stuff myself when they're gone.
47. I feel bloated after eating a normal meal.
48. I feel that people are happiest when they are children.
49. If I gain a pound, I worry that I will keep gaining.
50. I feel that I am a worthwhile person.
51. When I am upset, I don't know if I am sad, frightened, or angry.
52. I feel that I must do things perfectly or not do them at all.
53. I have the thought of trying to vomit in order to lose weight.
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).
55. I think that my thighs are just the right size.
56. I feel empty inside (emotionally).
57. I can talk about personal thoughts or feelings.
58. The best years of your life are when you become an adult.
59. I think my buttocks are too large.
60. I have feelings I can't quite identify.
61. I eat or drink in secrecy.
62. I think that my hips are just the right size.
63. I have extremely high goals.
64. When I am upset, I worry that I will start eating.
65. People I really like end up disappointing me.
66. I am ashamed of my human weaknesses.
67. Other people would say that I am emotionally unstable.
68. I would like to be in total control of my bodily urges.
69. I feel relaxed in most group situations.
70. I say things impulsively that I regret having said.
71. I go out of my way to experience pleasure.
72. I have to be careful of my tendency to abuse drugs.
73. I am outgoing with most people.
74. I feel trapped in relationships.
75. Self-denial makes me feel stronger spiritually.
76. People understand my real problems.
77. I can't get strange thoughts out of my head.
78. Eating for pleasure is a sign of moral weakness.
79. I am prone to outbursts of anger or rage.
80. I feel that people give me the credit I deserve.
81. I have to be careful of my tendency to abuse alcohol.
82. I believe that relaxing is simply a waste of time.
83. Others would say that I get irritated easily.
84. I feel like I am losing out everywhere.

(Continued)

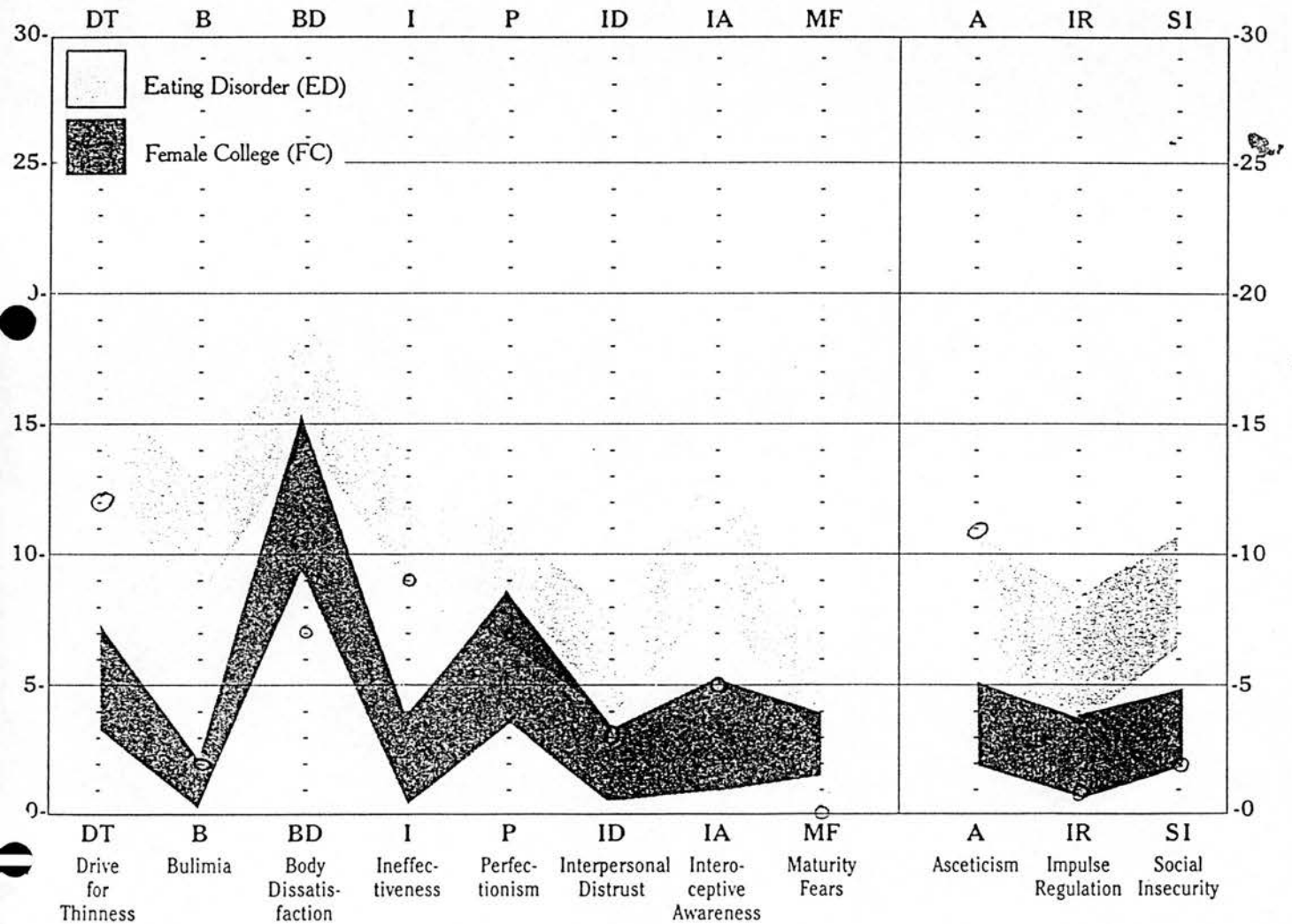
- 85. I experience marked mood shifts.
- 86. I am embarrassed by my bodily urges.
- 87. I would rather spend time by myself than with others.
- 88. Suffering makes you a better person.
- 89. I know that people love me.
- 90. I feel like I must hurt myself or others.
- 91. I feel that I really know who I am.

Additional copies available from:

PAR Psychological Assessment Resources, Inc.
P.O. Box 998/Odessa, Florida 33556/Toll-Free 1-800-331-TEST

EDI-2 PROFILE FORM

Name _____ Age _____ Sex _____ Date _____



Raw Score _____
 Percentile Score _____

Normative Group =

Normative Table =

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PAR Psychological Assessment Resources, Inc.
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The Body Shape Questionnaire

We should like to know how you have been feeling about your appearance over the PAST FOUR WEEKS. Please read each question and circle the appropriate number to the right. Please answer all the questions.

Name Date

OVER THE PAST FOUR WEEKS:	Never	Rarely	Sometimes	Often	Very Often	Always
1. Has feeling bored made you brood about your shape?	1	2	3	4	5	6
2. Have you been so worried about your shape that you have been feeling that you ought to diet?	1	2	3	4	5	6
3. Have you thought that your thighs, hips or bottom are too large for the rest of you?	1	2	3	4	5	6
4. Have you been afraid that you might become fat (or fatter)?	1	2	3	4	5	6
5. Have you worried about your flesh being not firm enough?	1	2	3	4	5	6
6. Has feeling full (e.g. after eating a large meal) made you feel fat?	1	2	3	4	5	6
7. Have you felt so bad about your shape that you have cried?	1	2	3	4	5	6
8. Have you avoided running because your flesh might wobble? ...	1	2	3	4	5	6
9. Has being with thin women made you feel self-conscious about your shape?	1	2	3	4	5	6
10. Have you worried about your thighs spreading out when sitting down?	1	2	3	4	5	6
11. Has eating even a small amount of food made you feel fat?	1	2	3	4	5	6
12. Have you noticed the shape of other women and felt that your own shape compared unfavourably?	1	2	3	4	5	6
13. Has thinking about your shape interfered with your ability to concentrate (e.g. while watching television, reading, listening to conversations)?	1	2	3	4	5	6
14. Has being naked, such as when taking a bath, made you feel fat?	1	2	3	4	5	6
15. Have you avoided wearing clothes which make you particularly aware of the shape of your body?	1	2	3	4	5	6
16. Have you imagined cutting off fleshy areas of your body?	1	2	3	4	5	6
17. Has eating sweets, cakes, or other high calorie food made you feel fat?	1	2	3	4	5	6

THE BODY SHAPE QUESTIONNAIRE

	Never	Rarely	Sometimes	Often	Very Often	Always
18. Have you not gone out to social occasions (e.g. parties) because you have felt bad about your shape?	1	2	3	4	5	6
19. Have you felt excessively large and rounded?	1	2	3	4	5	6
20. Have you felt ashamed of your body?	1	2	3	4	5	6
21. Has worry about your shape made you diet?	1	2	3	4	5	6
22. Have you felt happiest about your shape when your stomach has been empty (e.g. in the morning)?	1	2	3	4	5	6
23. Have you thought that you are the shape you are because you lack self-control?	1	2	3	4	5	6
24. Have you worried about other people seeing rolls of flesh around your waist or stomach?	1	2	3	4	5	6
25. Have you felt that it is not fair that other women are thinner than you?	1	2	3	4	5	6
26. Have you vomited in order to feel thinner?	1	2	3	4	5	6
27. When in company have you worried about taking up too much room (e.g. sitting on a sofa, or a bus seat)?	1	2	3	4	5	6
28. Have you worried about your flesh being dimply?	1	2	3	4	5	6
29. Has seeing your reflection (e.g. in a mirror or shop window) made you feel bad about your shape?	1	2	3	4	5	6
30. Have you pinched areas of your body to see how much fat there is?	1	2	3	4	5	6
31. Have you avoided situations where people could see your body (e.g. communal changing rooms or swimming baths)?	1	2	3	4	5	6
32. Have you taken laxatives in order to feel thinner?	1	2	3	4	5	6
33. Have you been particularly self-conscious about your shape when in the company of other people?	1	2	3	4	5	6
34. Has worry about your shape made you feel you ought to exercise?	1	2	3	4	5	6

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Private and Confidential

FOULDS AND BEDFORD P.D. INVENTORY AND SCALES

DSSI/NS. (R)

Please supply the following details about yourself:-

Full Name Sex

Date of Birth Today's Date Age

Marital Status

Occupation

	CVs	CPs	Ps	Rs	Ds
Ns					
Ts					

INSTRUCTIONS

This booklet contains descriptions of how you may have felt, thought, or acted recently.

After reading each statement you have to put a circle round either 'False' or 'True', depending upon which is the correct answer for you. On the occasions when you have marked 'True' you then have to indicate how much this upset you. Do this by putting a circle round the one phrase or word which best explains this.

If you had marked "False" with a circle you would just go on to read the next statement.

Your answers will be regarded as strictly confidential.

EXAMPLES

1. Recently I have been getting frequent headaches.

False

☒ True

If true this has upset me:-

Unbearably

☒ A lot

A bit

The first example would mean that recently you have been getting frequent headaches which upset you a lot.

2. Recently my concentration has been poor.

False

☒ True

If true, this has upset me:-

☒ A bit

A lot

Unbearably

The second example would mean that recently your concentration has been poor, which upset you a bit.

3. Recently people have been getting on my nerves.

☒ False

True

If true, this has upset me:-

Unbearably

A lot

A bit

The third example would mean that recently people have *not* been getting on your nerves.

4. Recently I have worried about family troubles.

False

☒ True

If true, this has upset me:-

A bit

A lot

☒ Unbearably

The fourth example would mean that recently you had worried about family troubles, which had upset you unbearably.

If you are not sure what to do please ask now. Otherwise begin on the next page.

1. Recently I have lost the use of one of my arms *or* legs for a time.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

2. Recently I have been *unnecessarily* careful about carrying out even simple everyday tasks.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

3. Recently I have been afraid of heights.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

4. Recently I have been afraid of the thought that I might make a physical attack on someone.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

5. Recently I have been sleep-walking.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

6. Recently I lost my sight *or* hearing for a while and then it came back.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

7. Recently I have had to wash things *again and again* to make absolutely certain that they were safe.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

8. Recently I have had a fear of some harmless animal *or* insect.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

9. Recently I have had nagging doubts about nearly everything that I have done.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

10. Recently I have lost my memory and forgotten who I was, *or* where I lived.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

11. Recently I have often had difficulty in keeping my balance.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

12. Recently I have had to keep on checking things again and again *quite unnecessarily*.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

13. Recently I have been afraid of handling some weapon or sharp object.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

14. Recently I have had nagging fears that someone close to me might be killed or seriously injured.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

15. Recently all my behaviour became like that of a young child for quite some time.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

16. Recently I have been unable to control my violent shaking.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

17. Recently I have kept having to wash myself *again and again*.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

18. Recently I have had an *unreasonable* fear of germs.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

19. Recently nasty thoughts *or* words have kept running through my mind *against my will*.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

20. Recently people around me have seemed strange, unfamiliar, or different.

False

True

If true, are they really?

Not really

Not sure

Really are

21. Recently I have had fits.

False	True	If true, this has upset me:-
		Unbearably A lot A bit

22. Recently I have felt *compelled* to do things in a certain order, or a certain number of times, to guard against something going wrong.

False	True	If true, this has upset me:-
		A bit A lot Unbearably

23. Recently I have had a fear of enclosed spaces.

False	True	If true, this has upset me:-
		Unbearably A lot A bit

24. Recently I have been worried by the thought that certain things might have been left lying around.

False	True	If true, this has upset me:-
		A bit A lot Unbearably

25. Recently I have lost consciousness for a few seconds without actually falling.

False	True	If true, this has upset me:-
		Unbearably A lot A bit

26. Recently I have had pains which *moved about* to different parts of my body.

False	True	If true, this has upset me:-
		A bit A lot Unbearably

27. Recently I have felt *compelled* to keep on touching things.

False	True	If true, this has upset me:-
		Unbearably A lot A bit

28. Recently I have been frightened of going into crowds or social gatherings.

False	True	If true, this has upset me:-
		A bit A lot Unbearably

29. Recently I have had persistent feelings of having left something unfinished without knowing what.

False	True	If true, this has upset me:-
		Unbearably A lot A bit

30. Recently I have found myself in some place without knowing *why* I was there or *how* I got there.

False	True	If true, this has upset me:-
		A bit A lot Unbearably

31. Recently I have had burning *or* tingling sensations under my skin, which were much worse than 'pins and needles'.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

32. Recently I have been unable to stop myself from counting, *or* tapping things, *or* uttering phrases *quite* *pointlessly*.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

33. Recently I have been quite unable to bring myself to go out alone.

False

True

If true, this has upset me:-

Unbearably

A lot

A bit

34. Recently I have had an *unreasonable* fear that I might forget to do something and then something *really* *awful* might happen.

False

True

If true, this has upset me:-

A bit

A lot

Unbearably

35. Recently things around me have seemed odd, unfamiliar, or changed.

False

True

If true, are they really odd or do they just seem so?

Really are

Not sure

Not really

Now please check that you have circled 'False' or 'True' for every statement; and when 'True' was marked that one of the three choices is also circled.

HAD Scale

Name: _____

Date: _____

Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he will be able to help you more.

This questionnaire is designed to help your doctor to know how you feel. Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week.

Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response.

Tick only one box in each section

I feel tense or 'wound up':

Most of the time
A lot of the time
Time to time, Occasionally
Not at all

<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

I feel as if I am slowed down:

Nearly all the time
Very often
Sometimes
Not at all

<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

I still enjoy the things I used to enjoy:

Definitely as much
Not quite so much
Only a little
Hardly at all

<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

I get a sort of frightened feeling like 'butterflies' in the stomach:

Not at all
Occasionally
Quite often
Very often

<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

I get a sort of frightened feeling as if something awful is about to happen:

Very definitely and quite badly
Yes, but not too badly
A little, but it doesn't worry me
Not at all

<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

I have lost interest in my appearance:

Definitely
I don't take so much care as I should.....
I may not take quite as much care
I take just as much care as ever

<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

I can laugh and see the funny side of things:

As much as I always could
Not quite so much now
Definitely not so much now
Not at all

<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

I feel restless as if I have to be on the move:

Very much indeed
Quite a lot
Not very much
Not at all

<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

Worrying thoughts go through my mind:

A great deal of the time
A lot of the time
From time to time but not too often ..
Only occasionally

<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

I look forward with enjoyment to things:

As much as ever I did
Rather less than I used to
Definitely less than I used to
Hardly at all

<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

I feel cheerful:

Not at all
Not often
Sometimes
Most of the time

<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

I get sudden feelings of panic:

Very often indeed
Quite often
Not very often
Not at all

<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

I can sit at ease and feel relaxed:

Definitely
Usually
Not often
Not at all

<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

I can enjoy a good book or radio or TV programme:

Often
Sometimes
Not often
Very seldom

<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

Do not write below this line



Date: _____

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

This questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the **past week including today**, darken the circle with a 'T' indicating TRUE in the column next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' indicating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

- | | | |
|--|-------------------------|-------------------------|
| 1. I look forward to the future with hope and enthusiasm. | <input type="radio"/> T | <input type="radio"/> F |
| 2. I might as well give up because there is nothing I can do about making things better for myself. | <input type="radio"/> T | <input type="radio"/> F |
| 3. When things are going badly, I am helped by knowing that they cannot stay that way forever. | <input type="radio"/> T | <input type="radio"/> F |
| 4. I can't imagine what my life would be like in ten years. | <input type="radio"/> T | <input type="radio"/> F |
| 5. I have enough time to accomplish the things I want to do. | <input type="radio"/> T | <input type="radio"/> F |
| 6. In the future, I expect to succeed in what concerns me most. | <input type="radio"/> T | <input type="radio"/> F |
| 7. My future seems dark to me. | <input type="radio"/> T | <input type="radio"/> F |
| 8. I happen to be particularly lucky, and I expect to get more of the good things in life than the average person. | <input type="radio"/> T | <input type="radio"/> F |
| 9. I just can't get the breaks, and there's no reason I will in the future. | <input type="radio"/> T | <input type="radio"/> F |
| 10. My past experiences have prepared me well for the future. | <input type="radio"/> T | <input type="radio"/> F |
| 11. All I can see ahead of me is unpleasantness rather than pleasantness. | <input type="radio"/> T | <input type="radio"/> F |
| 12. I don't expect to get what I really want. | <input type="radio"/> T | <input type="radio"/> F |
| 13. When I look ahead to the future, I expect that I will be happier than I am now. | <input type="radio"/> T | <input type="radio"/> F |
| 14. Things just don't work out the way I want them to. | <input type="radio"/> T | <input type="radio"/> F |
| 15. I have great faith in the future. | <input type="radio"/> T | <input type="radio"/> F |
| 16. I never get what I want, so it's foolish to want anything. | <input type="radio"/> T | <input type="radio"/> F |
| 17. It's very unlikely that I will get any real satisfaction in the future. | <input type="radio"/> T | <input type="radio"/> F |
| 18. The future seems vague and uncertain to me. | <input type="radio"/> T | <input type="radio"/> F |
| 19. I can look forward to more good times than bad times. | <input type="radio"/> T | <input type="radio"/> F |
| 20. There's no use in really trying to get anything I want because I probably won't get it. | <input type="radio"/> T | <input type="radio"/> F |

THE PSYCHOLOGICAL CORPORATION
HARCOURT BRACE JOVANOVICH, INC.

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SELF-EVALUATION QUESTIONNAIRE

Developed by Charles D. Spielberger
in collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs
STAI Form V-1

Name _____ Sex: M _____ F _____ Date _____ S _____
Age _____ T _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel *right now*, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

NEVER
NOT AT ALL
SOMETIMES
VERY MUCH SO

1. I feel calm () () () ()
2. I feel secure () () () ()
3. I am tense () () () ()
4. I feel strained () () () ()
5. I feel at ease () () () ()
6. I feel upset () () () ()
7. I am presently worrying over possible misfortunes () () () ()
8. I feel satisfied () () () ()
9. I feel frightened () () () ()
10. I feel comfortable () () () ()
11. I feel self-confident () () () ()
12. I feel nervous () () () ()
13. I am jittery () () () ()
14. I feel indecisive () () () ()
15. I am relaxed () () () ()
16. I feel content () () () ()
17. I am worried () () () ()
18. I feel confused () () () ()
19. I feel steady () () () ()
20. I feel pleasant () () () ()

SELF-EVALUATION QUESTIONNAIRE

STAI Form V-2

Name _____ Date _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you *generally* feel.

ALMOST
NEVER
SOMETIMES
ALWAYS

21. I feel pleasant () () () ()
22. I feel nervous and restless () () () ()
23. I feel satisfied with myself () () () ()
24. I wish I could be as happy as others seem to be () () () ()
25. I feel like a failure () () () ()
26. I feel rested () () () ()
27. I am "calm, cool, and collected" () () () ()
28. I feel that difficulties are piling up so that I cannot overcome them () () () ()
29. I worry too much over something that really doesn't matter () () () ()
30. I am happy () () () ()
31. I have disturbing thoughts () () () ()
32. I lack self-confidence () () () ()
33. I feel secure () () () ()
34. I make decisions easily () () () ()
35. I feel inadequate () () () ()
36. I am content () () () ()
37. Some unimportant thought runs through my mind and bothers me () () () ()
38. I take disappointments so keenly that I can't put them out of my mind () () () ()
39. I am a steady person () () () ()
40. I get in a state of tension or turmoil as I think over my recent concerns and interests () () () ()

Self-Rating Questionnaire

STAXI Item Booklet (Form HS)

Name .

Sex

Age

Date .

Education

Occupation

Marital Status .

Instructions

In addition to this Item Booklet you should have a STAXI Rating Sheet. Before beginning, enter your name, sex, age, the date, your education and occupation, and your marital status in the spaces provided on this booklet and at the top of the Rating Sheet.

This booklet is divided into three Parts. Each Part contains a number of statements that people use to describe their feelings and behavior. Please note that each Part has *different* directions. Carefully read the directions for each Part before recording your responses on the Rating Sheet.

There are no right or wrong answers. In responding to each statement, give the answer that describes you best. DO NOT ERASE! If you need to change your answer, make an "X" through the incorrect response and then fill in the correct one.

Examples

- | | | | | |
|----|---|--------------|---|---|
| 1. | ① | ② | ③ | ④ |
| 2. | ① | ② | ③ | ④ |

Part 1 Directions

A number of statements that people use to describe themselves are given below. Read each statement and then fill in the circle with the number which indicates how you feel *right now*. Remember that there are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to *best* describe your *present feelings*.

Fill in ① for *Not at all*
Fill in ② for *Somewhat*

Fill in ③ for *Moderately so*
Fill in ④ for *Very much so*

How I Feel Right Now

1. I am furious.
2. I feel irritated.
3. I feel angry.
4. I feel like yelling at somebody.
5. I feel like breaking things.
6. I am mad.
7. I feel like banging on the table.
8. I feel like hitting someone.
9. I am burned up.
10. I feel like swearing.

Part 2 Directions

A number of statements that people use to describe themselves are given below. Read each statement and then fill in the circle with the number which indicates how you *generally* feel. Remember that there are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to *best* describe how you *generally* feel.

Fill in ① for *Almost never*
Fill in ② for *Sometimes*

Fill in ③ for *Often*
Fill in ④ for *Almost always*

How I Generally Feel

11. I am quick tempered.
12. I have a fiery temper.
13. I am a hotheaded person.
14. I get angry when I'm slowed down by others' mistakes.
15. I feel annoyed when I am not given recognition for doing good work.
16. I fly off the handle.
17. When I get mad, I say nasty things.
18. It makes me furious when I am criticized in front of others.
19. When I get frustrated, I feel like hitting someone.
20. I feel infuriated when I do a good job and get a poor evaluation.

Part 3 Directions

Everyone feels angry or furious from time to time, but people differ in the ways that they react when they are angry. A number of statements are listed below which people use to describe their reactions when they feel *angry* or *furious*. Read each statement and then fill in the circle with the number which indicates how *often* you *generally* react or behave in the manner described when you are feeling angry or furious. Remember that there are no right or wrong answers. Do not spend too much time on any one statement.

Fill in ① for *Almost never*
Fill in ② for *Sometimes*

Fill in ③ for *Often*
Fill in ④ for *Almost always*

When Angry or Furious...

21. I control my temper.
22. I express my anger.
23. I keep things in.
24. I am patient with others.
25. I pout or sulk.
26. I withdraw from people.
27. I make sarcastic remarks to others.
28. I keep my cool.
29. I do things like slam doors.
30. I boil inside, but I don't show it.
31. I control my behavior.
32. I argue with others.
33. I tend to harbor grudges that I don't tell anyone about.
34. I strike out at whatever infuriates me.
35. I can stop myself from losing my temper.
36. I am secretly quite critical of others.
37. I am angrier than I am willing to admit.
38. I calm down faster than most other people.
39. I say nasty things.
40. I try to be tolerant and understanding.
41. I'm irritated a great deal more than people are aware of.
42. I lose my temper.
43. If someone annoys me, I'm apt to tell him or her how I feel.
44. I control my angry feelings.

ROSENBERG SELF-ESTEEM QUESTIONNAIRE.

These are a series of statements about how you have felt about yourself. Please indicate your level of agreement with each statement by ticking the relevant box.

1. I feel that I am a person of worth,
at least on an equal plane with others

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

2. I feel that I have a good number
of qualities.

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

3. All in all, I am inclined to feel
that I am a failure.

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

4. I am able to do things as well as
most other people.

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

5. I feel I do not have much to be
proud of.

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

6. I take a positive attitude towards
myself.

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

7. On the whole, I am satisfied with
myself.

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

8. I wish I could have more respect
for myself.

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

9. I certainly feel useless at times.

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

10. At times I think that I am no
good at all.

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

MCMASTERS FAMILY ASSESSMENT DEVICE (GENERAL FUNCTIONING SCALE)

5. Please indicate with a cross in the relevant box, how much you feel that the following statements apply to your family. By family I mean the family you grew up with i.e. parents, brothers, sisters etc.

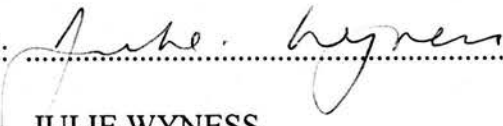
SD - Strongly Disagree	D - Disagree	A - Agree	SA - Strongly Agree
SD	D	A	SA
a) Planning family activities is difficult because we misunderstand each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) In times of crisis we can turn to each other for support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) We cannot talk to each other about the sadness we feel.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Individuals are accepted for what they are.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) We avoid discussing our fears and concerns.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) We can express feelings to each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) There are lots of bad feelings in the family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) We feel accepted for what we are.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Making decisions is a problem for our family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) We are able to make decisions about how to solve problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) We don't get along well together.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) We confide in each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TITLE: A CASE STUDY OF A CLIENT REFERRED TO A CLINICAL
PSYCHOLOGY DEPARTMENT FOR PSYCHOLOGICAL
ASSESSMENT AND TREATMENT OF AN EATING DISORDER.

JAMES I. ISLES

Submitted in part fulfilment of the degree of doctorate in Clinical Psychology
at the University of Edinburgh, February 2000

I certify that this report is a fair and accurate account of the work carried out.

Signed: 
JULIE WYNESS

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TITLE: A case study of a client referred to a clinical psychology department for psychological assessment and treatment of an eating disorder.

THE CLIENT:

Dee is a 34 year old female divorcee and a single parent who was referred by a Psychiatrist to Clinical Psychology with a mixed eating disorder.

PRESENTATION:

Dee presented on interview (Nov,1993) as a friendly, attractive woman of slight build. She described typical features of an eating disorder: over-valued ideation concerning her body image, a morbid fear of weight gain and a drive for thinness. (Bruch, 1973) In common with eating disorders, she held a strong belief that weight gain would lead to a perceived loss of control. (Garner and Bemiss,1985).

Dee's low weight was maintained by restrictive dieting, regular exercise and the occasional use of laxatives. Her weight on presentation was 79% of her optimum according to published scales and her Quetelet's mass body index was 17. (Metropolitan Life Insurance,1983) She was therefore at risk from 'starvation syndrome', (Cullen Centre, 1992). She had secondary amenorrhoea. Following the onset of her eating disorder two years ago, Dee was binge-eating and vomiting up to three times per week. On presentation however, she had experienced only one episode in the

previous six months due to a more regular dietary intake and nutritional counselling from a dietician. (She had discontinued her contact with her dietician however, due to her failure to achieve a marked increase in weight.)

Dee was aware that her eating behaviours were maladaptive and were triggered not only by hunger but also by the experience of unpleasant emotions. For example, on experiencing hurt she would comfort-eat and subsequently binge. On experiencing feelings of powerlessness or self-blame she would resort to weight control and/or vigorous exercise.

Prior to the onset of her eating disorder Dee recalls being a "happy go lucky person". She had since felt frequently low in mood with feelings of general discontent with her life. On presentation however, her mood had been stable and there was no evidence of the dysphoria state which often accompanies eating disorders. (Laessle, 1990)

On discussing her self-image, Dee described herself as someone who pursued perfectionism, was eager to please and who generally avoided confrontation. (Characteristics often associated with clients who have an eating disorder - Bruch, 1973, Godesit, 1985) Her preferred scenario' (Egan, 1990) concerning her body image and weight was to feel more comfortable about her body and attain a target of 90% of her optimum weight.

DIAGNOSTIC CONSIDERATIONS:

Dee's eating disorder at the time of interview neither met the criteria for Anorexia Nervosa nor Bulimia Nervosa for ICD 10. Her

presentation did however meet the criteria for Anorexia Nervosa for DSM III-R. (Refer Appendix 1) The features did not meet DSM III-R for Bulimia Nervosa due to the lack of regular binge-eating episodes. Her presentation did however suggest a mixed, possibly subclinical eating disorder.

PRECIPITATING FACTORS:

Prior to her eating disorder Dee's weight had been 90% of her optimum weight for several years. She attributed the onset of her eating disorder to difficulties which she was having in extricating herself from a relationship with a boyfriend two years ago. This man's need for sexual variance led to her feeling disgusted with herself. Dee wanted to finish this relationship but felt unable to do so because of her compliance behaviours and his persistency. At this time she developed a kidney infection with considerable weight loss. It occurred to her after losing weight, that further weight reduction may serve to make her less sexually attractive and cause him to lose interest in her.

This strategy proved to be unsuccessful however and eventually her parents intervened to help her dissolve the relationship. Dee continued dieting after this event, due to feelings of disgust with herself and a desire to feel less sexually attractive to men.

CONTRIBUTING FACTOR - MARRIAGE.

Dee's relationship with this boyfriend mirrored, to an extent her relationship with her ex-husband whom met when she was sixteen

and whom she married at nineteen. For the greater part of her 10 year marriage, Dee attempted to be a "perfect wife" - an aspiration reinforced by her husband who saw Dee's marital role as subservient to his own. He would also constantly refer to her body as perfect - a reference which she found embarrassing. After several years of feeling oppressed within her marriage, she left her husband and set up a new home for her and her two young children. She began full-time employment as a secretary.

CONTRIBUTING FACTOR -WORK:

Dee described her work as generally enjoyable. At times however, she felt frustrated due to the excessive work demands placed upon her by her employers. She felt that her eagerness to please was being abused and she subsequently felt resentful and angry with herself for "putting up with it".

CONTRIBUTING FACTORS-CHILDHOOD:

D is the eldest of three children. Her parents are both alive and in good health. She initially referred to her upbringing as having been a happy one. On further reflection however, she recalled many incidents of being scolded and slapped by her mother. She felt that she had always been afraid of her mother whom she described as domineering and unapproachable. She also recalled self-referenced blame in understanding her mother's apparent hostility towards her. Her related guilt for having angry feelings and nasty thoughts' about her mother was possibly the genesis of her acknowledged dichotomous thinking.

(Beck, 1975, Garner and Bellis, 1982)

On reflection, Dee considered that she may have dealt with such mixed childhood emotions by suppression and the pursuit of approval through compliance and perfectionism. A noted childhood response to hurt and confusion. (Saarni and Harris, 1989.

Miller, 1990, Herman, 1992)

Dee's description of her father was in stark contrast to that of her mother. She felt that her father was always loving and caring towards her and he would attempt to protect her from her mother's scolding. He was however in the army and away from the home for the first eight years of Dee's life. She felt that he too was subject to her mother's bullying and she has always felt sorry for him.

On further discussion of her upbringing there was no evidence of Dee having experienced child sexual abuse - a possible feature in the aetiology of eating disorders. (Hastings and Kern, 1994)

PROVISIONAL HYPOTHESES:

The above data was gathered over the course of several assessment interviews and provided sufficient information to begin to generate shared hypotheses. Dee reported at this stage that she was finding the sessions difficult due to an awareness that she was blaming others, and her mother in particular for her problems. Over the Xmas period. she had felt very low in mood and had experienced a relapse of binge-eating and vomiting behaviours. However, this provided an opportunity to attempt a functional analysis of her bulimic features and prepare a shared initial formulation of her eating disorder.

(Slade, 1982):-

H1.

That Dee's eating disorder was secondary to underlying issues concerning the conflict between the need to seek approval and subsequent resentment when feeling abused.

H2.

That this conflict arose from the development of childhood coping strategies as a response to dysfunctional parenting.

H3.

That Dee's eating disorder has served to provide her with a sense of control over her life when she felt oppressed and ineffectual.
(Bruch, 1973)

H4.

That her eating disorder served as a means to deal with unpleasant emotions, for example, anger and guilt.

H5.

That her eating disorder served as a means to avoid relationships with men and therefore anticipated feelings of hurt and abuse.

H6.

That her eating disorder served to neutralise fears of maturity
(separation-individuation model: Bruch, 1973, Swift, 1991)

PSYCHOMETRIC MEASURES:

1. Baker and McFadyen (1992) Client Questionnaire - pre-contact.
2. Eating Disorder Inventory (Garner and Olmsted, 1984) With particular reference to Ineffectiveness and Maturity Fears subscales.

3. New York State Self-Esteem Scale (Rosenberg, 1965)

4. McMasters Family Assessment Device (Hamilton, 1993)

The above hypotheses were further tested by exploratory counselling using Buzan diagrams (Appendix 3). Hypotheses nos 1 to 5 above were supported and form the basis of the initial formulation presented below. Dee scored highly on the Ineffectiveness subscale of the Eating Disorders Inventory thus supporting Hypothesis 3. Her score for the Maturity Fears subscale was low and Hypothesis 6 was therefore not pursued. Rosenberg's (1965) self-esteem scale yielded a low self-esteem measure on only 2 out of a 7 point scale. On a Lickert scale interpretation however, she scored 2.2. - Ingham et al (1987) found a that mean = 2.04 (sd2.03) occurred for a new case of depression and a mean =1.5 (sd1.54) occurred for a new case of anxiety/ minor depression. (cited by Hamilton, 1993)

The McMasters Family Assessment Device (Appendix 2) yielded a score of 2.4 (cut off = 2 for dysfunctional family -cited by Hamilton, 1993) and suggested that dysfunctional communication was the primary problem - a feature of family life associated with the aetiology of eating disorders. (Humphrey, 1991)

Baker and McFadyen's (1988) Patient Questionnaire confirmed that Dee's mood had been stable in the several weeks prior to initial interview. (Appendix 2)

FORMULATION:

The presenting problem of a mixed eating disorder appears to have been secondary to underlying issues concerning Dee's acknowledged difficulties in handling specific interpersonal relationships, ie, intra-psychic conflict between the need to seek approval through perfectionism and compliance and subsequent feelings of oppression and resentment which resulted when she felt abused. The consequence of this conflict was manifested by a: feelings of guilt arising from dichotomous thinking (that having bad thoughts or feelings about others is indicative of 'badness' on her part); b: that allowing herself to be 'abused' led to feelings of ineffectiveness and anger towards towards self.

Dee's eating disorder was precipitated by her experience of an oppressive relationship with an-ex-boyfriend and served to provide her with a perceived means of resolution by establishing control over one area of her life - her body. She thus appeared to derive a sense of being effective with 'ownership' of her body established. (Orbach, 1982, Goodsit, 1985)

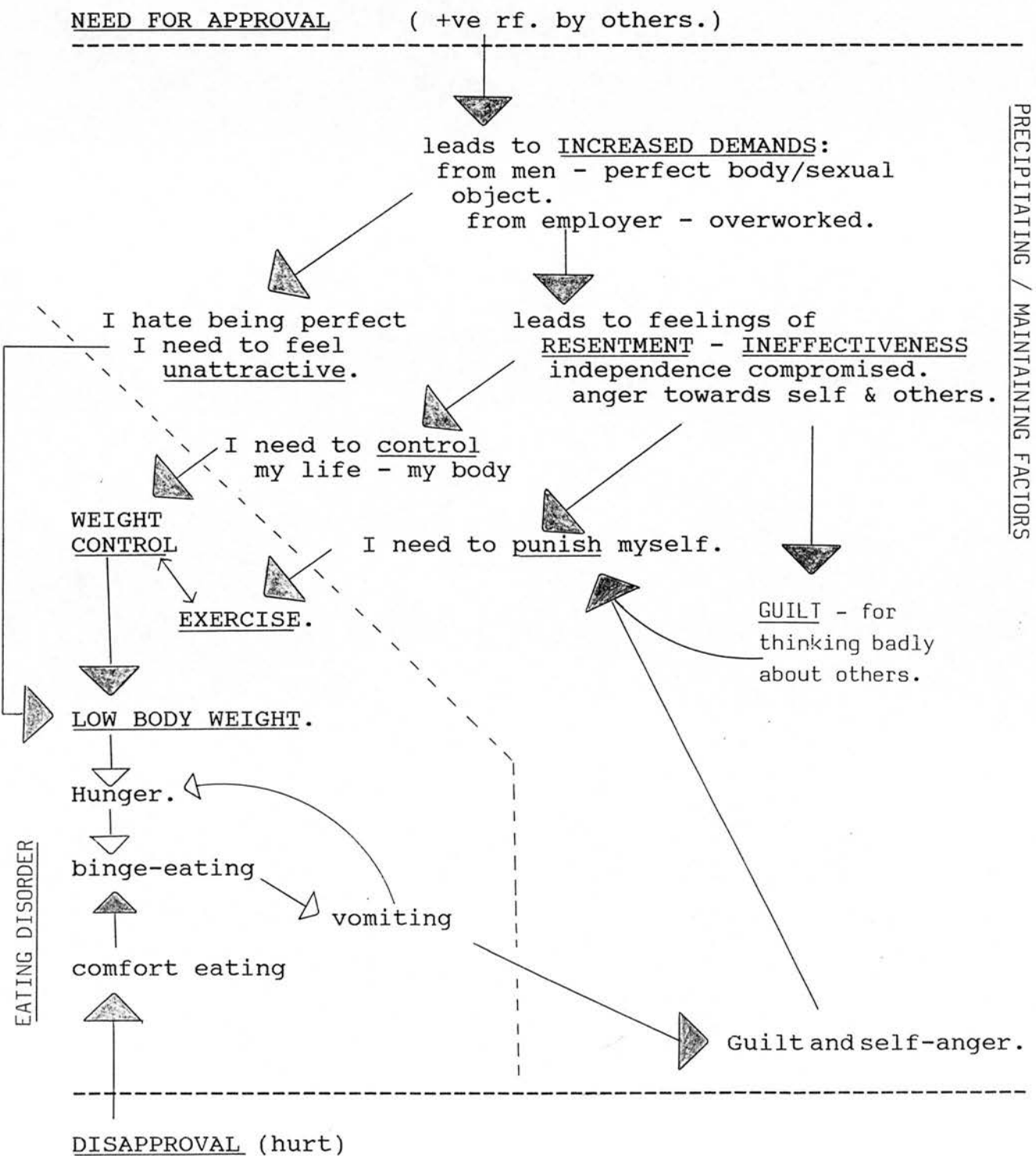
Weight reduction served to encourage her belief that men would find her less attractive. She would therefore not be confronted with the possibility of further hurt from a relationship.

Exercise provided Dee with the means to indirectly punish herself when feeling guilty about thinking badly about others and when chastising herself for allowing herself to be abused.

Disapproval, rejection and hurt were coped with by recourse to comfort eating with subsequent compounding of her eating

disorder. This formulation is represented diagrammatically below.

Figure 1: diagrammatic representation of case formulation.



INTERVENTION:

Following discussion of the above formulation, it became clear to Dee that in order to resolve her eating disorder, she would firstly have to learn to like herself more. Thus the following psychological interventions were employed to address the underlying issue of low self esteem:

1. A cognitive restructuring approach was used to help Dee become aware of and begin to challenge her apparent dichotomous thinking and irrational belief system. (Garner, 1985, Fairburn and Cooper, 1989)
2. Assertiveness training - to improve her confidence in asserting herself using specific examples from her current life. (Agras, 1987, Fichter, 1990, Nutzinger and de Zwaan, 1990)
3. Specific behavioural tasks to test out the reality of her fear that being assertive would lead to disapproval. (Dryden, 1987)
4. Further exploratory counselling and behavioural tasks to facilitate the expression of suppressed thoughts and emotion. (Prochaska, 1984, Fichter, 1990) For example, writing emotion-laden letters to significant others (not for sending). (Parks, 1990)
5. Bibliotherapy - A. Dickson (1982) A Woman in your own right. D., Burns (1980) Feeling Good: The new mood therapy.

OUTCOME:

The author's contact with Dee extended over 15 hourly sessions. Her progress was recently evaluated formally and the following

evaluative data gathered:

Qualitative Data- subjective reports of increased self-esteem:
for example -

1. " I feel that recently I have grown up....I've spent most of my life trying to please others now I'm going to consider my own needs more....."
2. I like myself a lot better now"
3. There's no-one to keep weight off for...I now feel more ready to put on weight than I have done in the past two years".

This apparent improvement in Dee's self esteem and confidence was further suggested by behavioural change such as:

1. Being able to say to her employer that she felt overworked.
2. Being able to contact her ex-husband to ask for maintenance money without feeling guilty.
3. Being able to (without prompting) increase calorific intake by 200 calories daily.

Psychometric measures:

1. Baker and McFadyen (1992) Client Questionnaire:

This questionnaire was given pre-and post contact. The symptom scores on both pre and post questionnaires are below the level considered to be dysfunctional. (Refer appendix 1)

2. Watson and Marks Life Impairment Scale (1971) -included in Baker and McFadyen's (1992) Patient Questionnaire.

Life Impairment Scale - maximum score = 8 (Lickert Scale).

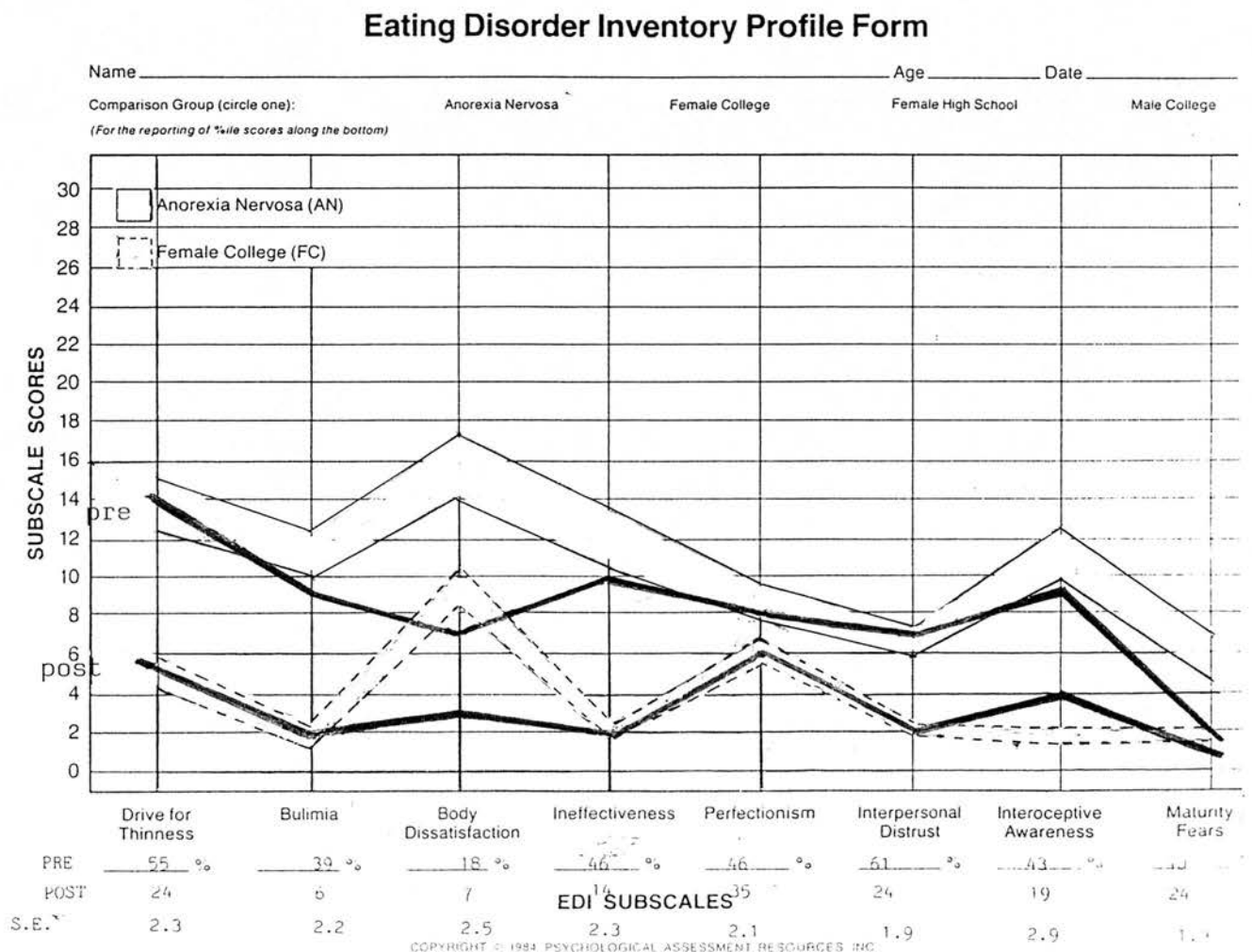
	Pre:	Post:
Social Leisure Activities -	4	3
Private " "	4	0
Family " "	0	2

Note: The increase in the latter score may reflect Dee's more assertive approach towards her family.

3. Eating Disorder Inventory (Garner and Olmsted, 1984)

Dee's scores are all reduced and yield marked improvement in 6 from 8 subscales including Ineffectiveness. (Refer Figure 2 and Appendix 2)

Figure 2. Eating Disorder Inventory Profile - Pre and Post Scores.



4. New York State Self-Esteem Scale (Rosenburg, 1965)

Lickert Scale score suggests an increase in self-esteem (from mean=2.2 to mean=1.9) However, this score is still indicative of low self-esteem when compared with Ingham et al's (1987) data, which suggests that a mean=1.18 (sd=1.45) is required for no new episode of depression/anxiety. (cited by Hamilton,1993) When Rosenberg's scale is scored in the traditional manner however, there are no negative self-esteem indices.

DISCUSSION:

This case study illustrates the need for a psychological formulation to be established prior to psychological intervention. Although the assessment process is in itself therapeutic by virtue of for example, the facilitation of a safe environment in which the client may express thoughts and feelings hitherto suppressed; it is the shared formulation with the client which may be an essential feature of therapeutic contact.

(Fichter,1990a) By understanding the nature of the problem and its maintaining factors, the client is in a better position to consider behavioural change - to move perhaps from pre-contemplation or contemplation to action. (Prochaska and Diclemente, 1982)

The author, a Trainee Clinical Psychologist was tempted to offer a cognitive-behavioural package as an early intervention to help Dee restore weight. Supervision however, emphasised caution and the need to firstly pursue a shared formulation which would

determine the nature of the intervention. Dee herself, felt that she benefited greatly from the process of exploratory counselling and would not have been otherwise been able to consider weight gain.

It is possible that she may have attempted to comply with an early 'intervention package' to avoid disapproval from the author. Such an approach may have therefore reinforced her need for approval and may have led to perceived ineffectiveness. Later in therapy Dee spontaneously began to increase her calorific intake by 200 cals. daily. The author attempted to capitalise on her motivation by proposing exercise reduction. Dee's immediate response was one of agreement. Her non-verbal behaviour suggested however that such a proposition was not entirely satisfactory. On raising this issue with her, she admitted that she would have tried to reduce her level of exercise for the author's benefit only!

On reviewing her therapeutic contact with the author, Dee concluded that she had made considerable progress in her attempts to resolve her eating disorder. She was aware that she has another important stage to work through - the attainment of her target weight. She plans to achieve this through gradual increase in her dietary intake. However she may require assistance to do this from Clinical Psychology and the author has therefore arranged for her to be reviewed by his clinical supervisor.

Note: Correspondence to the referring Psychiatrist is included in Appendix 4.

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APPENDIX: 1 -

Diagnostic Criteria for Anorexia Nervosa according
to the Diagnostic and Statistical Manual for Mental Disorders -
Revision (DSM-III-R) of the American Psychiatric Association
(1987) (Shortened) -

1. Refusal to maintain body weight over a minimal weight for age and height, for example, weight loss leading to maintenance of body weight 15 % below that expected, or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.
2. Intense fear of gaining weight or becoming fat, even though under weight.
3. Disturbance in the way in which one's body weight, size, or shape is experienced, for example, the person claims to 'feel fat' even when emaciated, believes that one area of the body is 'too fat' even when obviously underweight.
4. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). A woman is considered to have amenorrhea if her periods occur only following hormone, eg oestrogen, administration.

Reference: Fichter (1990)

APPENDIX 2: PSYCHOMETRIC MEASURES USED IN THIS CASE STUDY.

MCMASTER FAMILY ASSESSMENT DEVICE (GENERAL FUNCTIONING SCALE)

This test is based on McMasters model of family functioning and is designed to distinguish between healthy functioning families and dysfunctional families of origin. It taps the following areas: problem solving, communications, roles, affective responsiveness, affective involvement and behaviour control. Cut off score = .2 for dysfunctional family. Diagnostic confidence of test 0.83. (Taken from Hamilton,1993)

EATING DISORDER INVENTORY (GARNER & OLMSTED,1984)

The Eating Disorder Inventory (EDI) is a 64-item, self-report measure which consists of eight subscales;

The EDI is used here as an outcome measure.

Pre- and post therapy scores:

	Pre	Post	Standard Error for Anorexia Nervosa.
Drive for thinness -	16	9	2.3
Bulimia -	9	2	2.2
Body dissatisfaction -	7	3	2.5
Ineffectiveness -	10	2	2.3
Perfectionism -	8	6	2.1
Interpersonal distrust -	7	2	1.9
Interoceptive awareness -	9	4	2.9
Maturity fears -	2	1	1.9

Note: No cut off score - scores are compared with sample population group eg. Anorexia Nervosa. Outcome is considered to show marked change if point differentials between pre and post questionnaires are beyond standard error of the comparison group.

BAKER & MCFADYEN (1988) PATIENT QUESTIONNAIRE.

This is a 49-item self-report shortened version of the Bedford and Foulds Delusion - Symptoms - States - Inventory (DSSI) (Bedford and Foulds, 1978 -NFER-Nelson Publications)

The shortened version of the DSSI contains 7 subscales of 7 items measuring anxiety state, conversion symptoms, obsessional symptoms, depressive state, phobic symptoms, intrusive thinking and dissociative symptoms. It assesses whether or not each symptom has occurred within the previous 2-3 weeks and if so how much these symptoms have upset the person (number of symptoms and severity of symptoms). A cut off score >4 is considered to be dysfunctional.

Results:

<u>Subscale:</u>	<u>Pre:</u>	<u>Post:</u>
Anxiety - no. of symptoms	2	0
Anxiety - severity	2	0
Depression - no. of symptoms	2	0
Depression - severity	2	0
All other subscales	0	0

The Patient Questionnaire includes the Watson and Marks Life Impairment Scale (Watson and Marks, 1971) on a 8 point likert scale. There is no cut off point.

Results:

	<u>Pre:</u>	<u>Post:</u>
Social leisure activities	4	3
Private " "	4	0
Family " "	0	2
Work	0	0
Home management	0	0
Sexual relations	not applicable	

NEW YORK STATE SELF-ESTEEM SCALE (ROSENBERG,1965)

The scale is a 10-item Guttman scale with a coefficient of Reproducibility of 92% and a coefficient of Scalability of 72% Ingham et al (1987) found a mean = 2.04 (sd 2.03) occurred for a new case of major depression, a mean = 1.5 (sd 1.54) occurred for a new case of anxiety or minor depression, and a mean = 1.18 (sd 1.45) occurred for no new episode. (Hamilton, 1993)

<u>Results:</u>	<u>Pre</u>	<u>Post</u>
	2.2	1.9

PATIENT QUESTIONNAIRE

22

This booklet asks you questions about how you have been feeling recently (last 2 – 3 weeks).

There is no need to spend ages on each question – a first reaction is usually the best. If you get tired of answering questions it's O.K. to take a break and come back to it later

Your answers will be regarded as strictly confidential

Name

Address

Telephone Today's Date

Sex ☐ Male ☐ Female

Marital status (please tick boxes)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Single	1st Marriage	2nd Marriage	3+ Marriage	Co-habiting	Separated	Widowed	Divorced

Number of Children Ages

Occupation

Band's/Wife's Occupation

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Compiled by Roger Baker and Malcolm McFadyen, Community Services Department of Clinical Psychology,

36 Cornhill Road, Aberdeen

December 1988

INSTRUCTIONS

Here are some descriptions of how you may have felt, thought, or acted recently. After reading each statement you have to put a circle round either "False" or "True", depending upon which is the correct answer for you. On the occasions when you have marked "True", you then have to indicate how much this upset you. Do this by putting a circle round the one phrase or word which best explains this.

If you have marked "False" with a circle you would just go on to the next statement.

EXAMPLES

- A. Recently my concentration has been poor
If true, this has upset me: False True
A bit A lot Unbearably

This first example would mean that recently your concentration has been poor, which upset you a bit

- B. Recently people have been getting on my nerves
If true, this has upset me: False True
Unbearably A lot A bit

The second example would mean that recently people have NOT been getting on your nerves

 NOW PLEASE BEGIN

- | | | | | |
|----|---|--------------|-------|------------|
| 1. | Recently I have been breathless <i>or</i> had a pounding of my heart.

If true, this has upset me: | False | True | |
| | | <u>A bit</u> | A lot | Unbearably |
| 2. | Recently I have lost the use of one of my arms or legs for a time.

If true, this has upset me: | False | True | |
| | | Unbearably | A lot | A bit |
| 3. | Recently I have been <i>unnecessarily</i> careful about carrying out even simple everyday tasks.

If true, this has upset me: | False | True | |
| | | A bit | A lot | Unbearably |
| 4. | Recently the future has seemed hopeless.

If true, how hopeless? | False | True | |
| | | A bit | A lot | Completely |
| 5. | Recently I have been afraid of heights.

If true, this has upset me: | False | True | |
| | | Unbearably | A lot | A bit |
| 6. | Recently I have had nagging doubts about nearly everything that I have done.

If true, this has upset me: | False | True | |
| | | Unbearably | A lot | A bit |
| 7. | Recently I have been sleep-walking.

If true, this has upset me: | False | True | |
| | | Unbearably | A lot | A bit |

8.	Recently, for no good reason, I have had feelings of panic. If true, this has upset me:	False Unbearably	True A lot	A bit
9.	Recently I lost my sight <i>or</i> hearing for a while and then it came back. If true, this has upset me:	False A bit	True A lot	Unbearably
10.	Recently I have been unable to stop myself from counting, <i>or</i> tapping things, <i>or</i> uttering phrases <i>quite pointlessly</i> . If true, this has upset me:	False Unbearably	True A lot	A bit
11.	Recently I have lost interest in just about <i>every-thing</i> . If true, how much loss?	False Complete	True A lot	A bit
12.	Recently I have had a fear of some harmless animal <i>or</i> insect. If true, this has upset me:	False A bit	True A lot	Unbearably
13.	Recently I have been afraid of the thought that I might make a physical attack on someone. If true, this has upset me:	False A bit	True A lot	Unbearably
14.	Recently I have lost my memory and forgotten who I was, <i>or</i> where I lived. If true this has upset me:	False A bit	True A lot	Unbearably
15.	Recently I have been so 'worked up' that I couldn't sit still. If true, this has upset me:	False Unbearably	True A lot	A bit
16.	Recently I have had pains which <i>moved about</i> to different parts of my body. If true, this has upset me:	False A bit	True A lot	Unbearably
17.	Recently I have had to keep on checking things again and again <i>quite unnecessarily</i> . If true, this has upset me:	False Unbearably	True A lot	A bit
18.	Recently I have been so depressed that I have thought of doing away with myself. If true, how seriously?	False Completely	True Very	Not very
19.	Recently I have been afraid of handling some weapon or sharp object. If true, this has upset me:	False A bit	True A lot	Unbearably
20.	Recently I have had an <i>unreasonable</i> fear that I might forget to do something and then some-thing <i>really awful</i> might happen. If true, this has upset me:	False A bit	True A lot	Unbearably
21.	Recently all my behaviour became like that of a young child for quite some time. If true, this has upset me:	False A bit	True A lot	Unbearably

22.	Recently I have had a pain <i>or</i> tense feeling in my neck <i>or</i> head.	False	True	
	If true, this has upset me:	Unbearably	A lot	A bit
23.	Recently I have often had difficulty in keeping my balance.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
24.	Recently I have kept having to wash myself <i>again and again</i> .	False	True	
	If true, this has upset me:	Unbearably	A lot	A bit
25.	Recently I have been so miserable that I have had difficulty with my sleep.	False	True	
	If true this has upset me:	Unbearably	A lot	A bit
26.	Recently I have had an <i>unreasonable</i> fear of germs.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
27.	Recently I have had nagging fears that someone close to me might be killed or seriously injured.	False	True	
	If true this has upset me:	A bit	A lot	Unbearably
28.	Recently people around me have seemed strange, unfamiliar, or different.	False	True	
	If true, are they <i>really</i> ?	Not really	Not sure	Really are
29.	Recently I have worried about every little thing.	False	True	
	If true, this has upset me:	Unbearably	A lot	A bit
30.	Recently I have been unable to control my violent shaking.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
31.	Recently I have felt <i>compelled</i> to do things in a certain order, <i>or</i> a certain number of times, to guard against something going wrong.	False	True	
	If true, this has upset me:	Unbearably	A lot	A bit
32.	Recently I have been so low in spirits that I have sat for ages doing absolutely nothing.	False	True	
	If true this has upset me:	Unbearably	A lot	A bit
33.	Recently I have had a fear of enclosed spaces.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
34.	Recently nasty thoughts <i>or</i> words have kept running through my mind <i>against my will</i> .	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
35.	Recently things around me have seemed odd, unfamiliar, or changed.	False	True	
	If true, are they really odd or do they just seem so?	Not really	Not sure	Really are

	If true, this has upset me:	Unbearably	A lot	A bit
37.	Recently I had fits.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
38.	Recently I have had to wash things <i>again and again</i> to make absolutely certain that they were safe.	False	True	
	If true, this has upset me:	Unbearably	A lot	A bit
39.	Recently I have been depressed without knowing why.	False	True	
	If true, how depressed?	Extremely	Very	Fairly
40.	Recently I have been frightened of going into crowds or social gatherings.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
41.	Recently I have been worried by the thought that certain things might have been left lying around.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
42.	Recently I have lost consciousness for a few seconds without actually falling.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
43.	Recently I have been so anxious that I couldn't make up my mind about the simplest thing.	False	True	
	If true, how anxious?	Extremely	Very	Fairly
44.	Recently I have had burning <i>or</i> tingling sensations under my skin which were much worse than "pins and needles".	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
45.	Recently I have felt <i>compelled</i> to keep on touching things.	False	True	
	If true, this has upset me:	Unbearably	A lot	A bit
46.	Recently I have gone to bed not caring if I never woke up.	False	True	
	If true, how serious was this?	Desperately	Very	Fairly
47.	Recently I have been quite unable to bring myself to go out alone.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
48.	Recently I have had persistent feelings of having left something unfinished without knowing what.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably
49.	Recently I have found myself in some place without knowing <i>why</i> I was there or <i>how</i> I got there.	False	True	
	If true, this has upset me:	A bit	A lot	Unbearably

Now please check that you have circled 'False' or 'True' for every statement: and when 'True' was marked that one of the three choices is also circled.

INSTRUCTIONS

Below is a list of specific body sensations that may occur when you are nervous or in a feared situation. Choose a number from the code below to show how afraid you are of each feeling. Write the number in the box next to each feeling. CODE: 0 = I do not have this sensation.

- I have this sensation and I am
- | | |
|----|---|
| 1. | Not frightened or worried by this sensation |
| 2. | Somewhat frightened by this sensation |
| 3. | Moderately frightened by this sensation |
| 4. | Very frightened by this sensation |
| 5. | Extremely frightened by this sensation |

Heart palpitations

☐

Having a lump in your throat

☐

Pressure or a heavy feeling in chest

☐

Wobbly or rubber legs

☐

Numbness in arms or legs

☐

Sweating

☐

Tingling in the fingertips

☐

A dry throat

☐

Numbness in another part of your body

☐

Feeling disoriented and confused

☐

Feeling short of breath

☐

Feeling disconnected from your body or only part of you is here

☐

Dizziness

☐

Feelings of unreality

☐

Blurred or distorted vision

☐

A feeling of dread or impending doom

☐

Nausea

☐

Any other feelings: Please describe and rate them

Having "Butterflies" in your stomach

☐..... ☐

Feeling a knot in your stomach

☐..... ☐

THOUGHTS

INSTRUCTIONS

Below are some thoughts or ideas that may pass through your mind when you are nervous or frightened. Choose a number from the scale below to show how often each thought occurs when you are nervous. Write the number in the box next to each thought. CODE:

1. Thought never occurs
2. Thought rarely occurs
3. Thought occurs during half of the times I am nervous
4. Thought usually occurs
5. Thought always occurs when I am nervous

I am going to throw up

☐

I will be paralysed by fear

☐

I am going to pass out

☐

I will die

☐

I must have a brain tumour

☐

I will never be cured

☐

I will have a heart attack

☐

I will be overwhelmed

☐

I will choke to death

☐

I will be lost and not able to get back to reality

☐

I am going to act foolish

☐

I will be permanently harmed

☐

I am going blind

☐

I will disintegrate personally and emotionally

☐

I will not be able to control myself

☐

I am having a nervous breakdown

☐

I will hurt someone

☐

This experience will never end

☐

I am going to have a stroke

☐

Any other feelings: Please describe and rate them

I am going to go crazy

☐..... ☐

I am going to scream

☐..... ☐

I am going to babble or talk funny

☐

0	1	2	3	4	5	6	7	8
---	---	---	---	---	---	---	---	---

Always
avoid it

Talking to people in authority

7

7

0	1	2	3	4	5	6	7	8
---	---	---	---	---	---	---	---	---

Very severely
troublesome

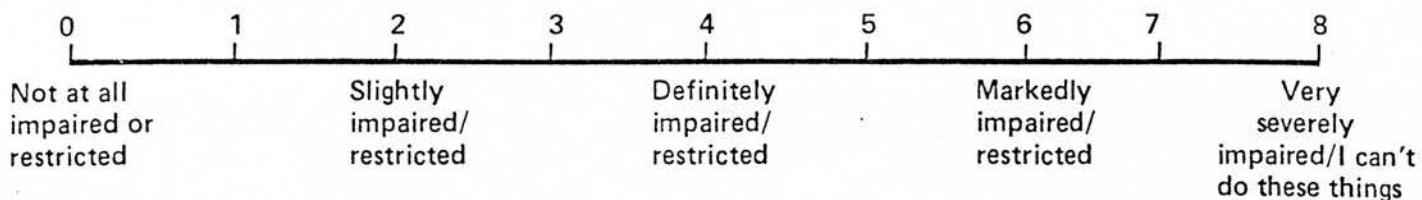
Feeling you or your surroundings are strange or unreal

0	1	2	3	4	5	6	7	8
---	---	---	---	---	---	---	---	---

Very severely
disturbing/
disabling

INSTRUCTIONS

Choose a number from the sliding scale below to show how much the various areas of your life are impaired or restricted because of your problems and write it in the box opposite each problem



NOTE: If any area does not apply to you, write N/A

- Work ☐
- Home management (cleaning, tidying, shopping, cooking, looking after home and or children) ☐
- Social leisure activities (with other people, eg parties, pubs, clubs, outings, visits, dating, home entertainment) ☐
- Private leisure activities (done alone, eg reading, gardening, collecting, sewing, walking alone) ☐
- Family relationships (including relationship with husband/wife) ☐
- Sexual relations ☐

Any other areas of your life which are impaired or restricted because of your problems? Please describe and rate

..... ☐

..... ☐

PANIC ATTACKS

INSTRUCTIONS

A panic attack is defined as:

- 1) A high level of anxiety along with
- 2) Strong bodily reactions (dizziness, heart palpitations, sweating, shaking or trembling, feeling sick, feelings of unreality, going hot and cold, chest pains) and
- 3) It seems as if you lose the ability to plan, think or reason and
- 4) You desperately want to escape or flee from the situation or stop the feelings

(This is different from high anxiety or fear alone)

Please tick boxes that apply to you

- I have never had a panic attack ☐
- I'm not sure if I've had a panic attack ☐

VERY RECENT ATTACKS

- I have had a panic attack in the last 7 days ☐
- How many panic attacks did you have in the last 7 days ? ☐

On average how severe or intense have they been? (tick one box)

- very mild ☐ mild ☐ moderately severe ☐ very severe ☐ extremely severe ☐

LESS RECENT ATTACKS

- I have had a panic attack but not in the last 7 days ☐

When was your last panic attack?





(e.g. "June 1986" or between 5-10th Sept 1987 "or" 14.2.87")

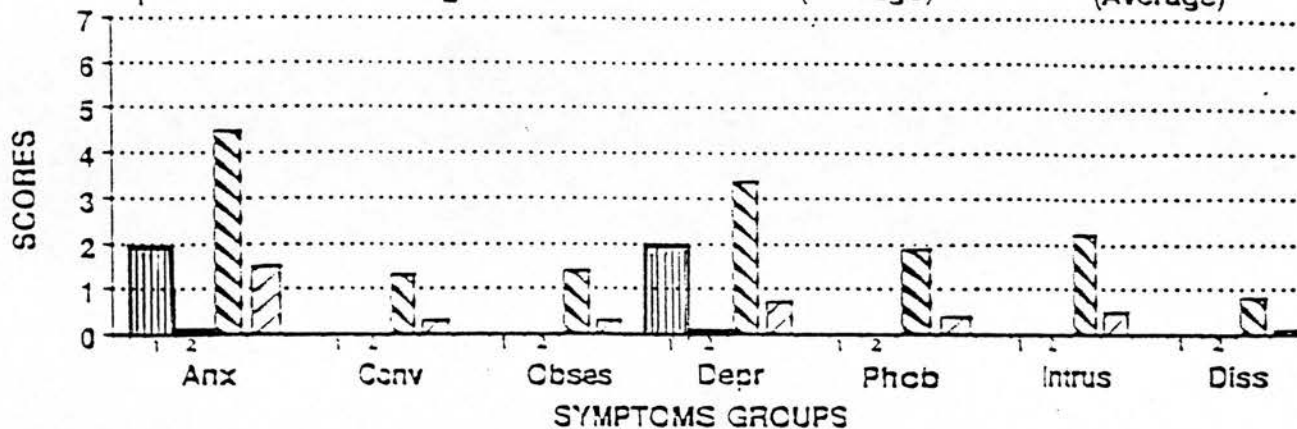
THANK YOU FOR FILLING IN THIS QUESTIONNAIRE

NAME _____ DATE OF ASSESSMENT 1: 12.11.03

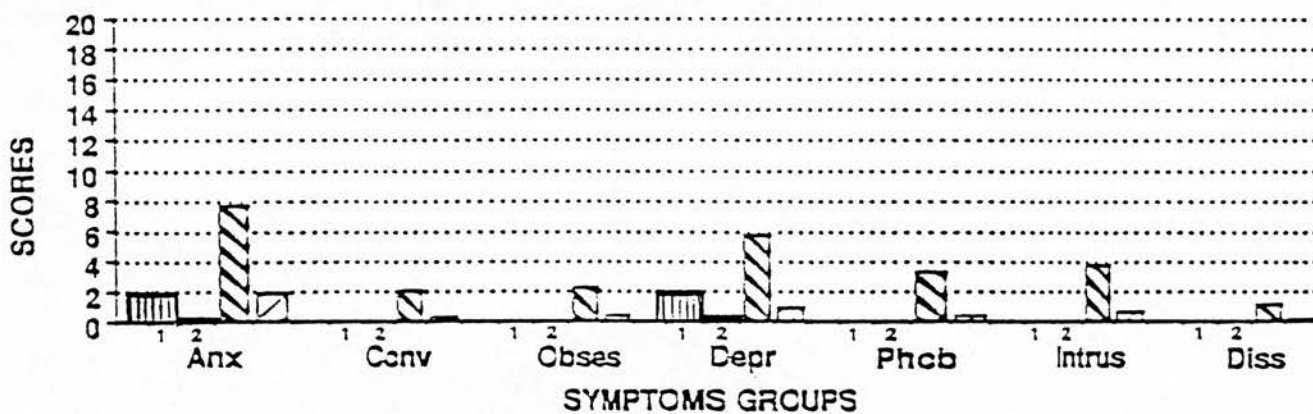
CLINICIAN _____ DATE OF ASSESSMENT 2: March 94

DSS: NUMBER OF SYMPTOMS

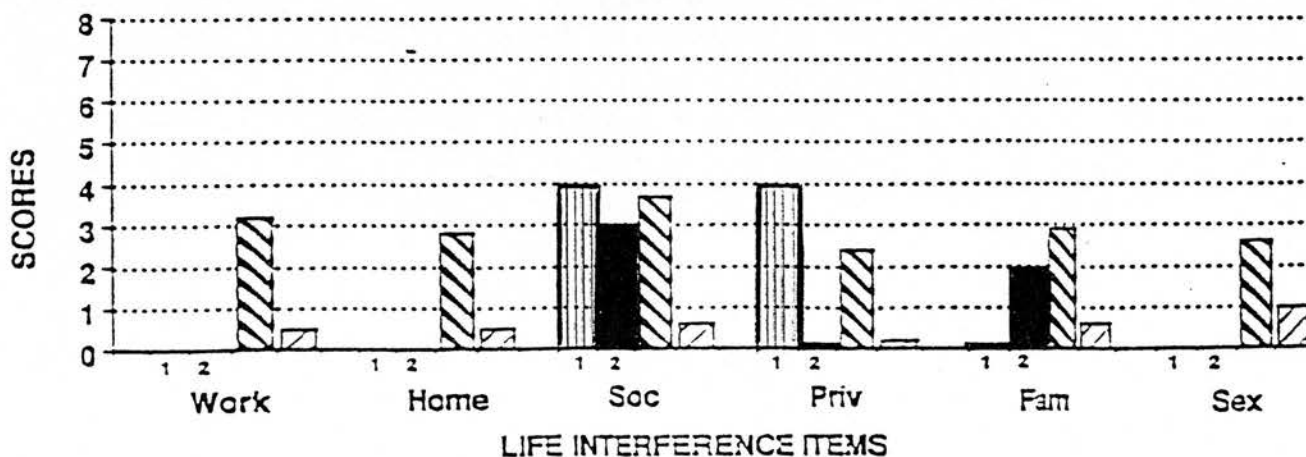
KEY:  Client Rating 1  Client Rating 2  Anxiety Group (Average)  Aberdeen sample (Average)



DSS: SEVERITY OF SYMPTOMS



LIFE INTERFERENCE SCALE



Other Comments _____

EDI

David M. Garner, Ph. D.
Marion P. Olmsted, M.A.
Janet Polivy, Ph. D.

Name _____ Date January 1994

Age _____ Sex _____ Marital status _____

Present weight _____ Height _____

Highest past weight (excluding pregnancy) _____ (lbs)

How long ago? _____ (months)

How long did you weigh this weight? _____ (months)

Lowest past adult weight _____ (lbs)

How long ago? _____ (months)

How long did you weigh this weight? _____ (months)

What do you consider your ideal weight? _____ (lbs)

Age at which weight problems began (if any) _____

Present occupation _____

Father's occupation _____ Mother's occupation _____

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Assessment
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9 8 7 6 5 4 3 2 1

Printed in the U.S.A.

This form is printed in blue ink on white paper. Any other version is unauthorized.

INSTRUCTIONS

This is a scale which measures a variety of attitudes, feelings and behaviors. Some of the items relate to food and eating. Others ask you about your feelings about yourself. THERE ARE NO RIGHT OR WRONG ANSWERS SO TRY VERY HARD TO BE COMPLETELY HONEST IN YOUR ANSWERS. RESULTS ARE COMPLETELY CONFIDENTIAL. Read each question and fill in the circle under the column which applies best to you. Please answer each question *very* carefully. Thank you.

	ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
1. I eat sweets and carbohydrates without feeling nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
2. I think that my stomach is too big.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I wish that I could return to the security of childhood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
4. I eat when I am upset.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I stuff myself with food.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I wish that I could be younger.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
7. I think about dieting.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I get frightened when my feelings are too strong.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I think that my thighs are too large.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
10. I feel ineffective as a person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I feel extremely guilty after overeating.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I think that my stomach is just the right size.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
13. Only outstanding performance is good enough in my family.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. The happiest time in life is when you are a child.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I am open about my feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
16. I am terrified of gaining weight.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I trust others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I feel alone in the world.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I feel satisfied with the shape of my body.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
20. I feel generally in control of things in my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
21. I get confused about what emotion I am feeling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I would rather be an adult than a child.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I can communicate with others easily.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I wish I were someone else.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
25. I exaggerate or magnify the importance of weight.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. I can clearly identify what emotion I am feeling.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. I feel inadequate.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. I have gone on eating binges where I have felt that I could not stop.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
29. As a child, I tried very hard to avoid disappointing my parents and teachers.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. I have close relationships.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

	ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
31. I like the shape of my buttocks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. I am preoccupied with the desire to be thinner.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. I don't know what's going on inside me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. I have trouble expressing my emotions to others.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. The demands of adulthood are too great.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. I hate being less than best at things.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. I feel secure about myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. I think about bingeing (over-eating).	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
39. I feel happy that I am not a child anymore.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. I get confused as to whether or not I am hungry.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
41. I have a low opinion of myself.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
42. I feel that I can achieve my standards.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
43. My parents have expected excellence of me.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44. I worry that my feelings will get out of control.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45. I think that my hips are too big.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
46. I eat moderately in front of others and stuff myself when they're gone	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
47. I feel bloated after eating a normal meal.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
48. I feel that people are happiest when they are children.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
49. If I gain a pound, I worry that I will keep gaining.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
50. I feel that I am a worthwhile person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
51. When I am upset, I don't know if I am sad, frightened, or angry. .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
52. I feel that I must do things perfectly, or not do them at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
53. I have the thought of trying to vomit in order to lose weight.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
55. I think that my thighs are just the right size.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
56. I feel empty inside (emotionally).	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
57. I can talk about personal thoughts or feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
58. The best years of your life are when you become an adult.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
59. I think that my buttocks are too large.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
60. I have feelings that I can't quite identify.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
61. I eat or drink in secrecy.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
62. I think that my hips are just the right size.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
63. I have extremely high goals.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
64. When I am upset, I worry that I will start eating.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*

*

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16	9	7	10	8	7	9	2
DT	B	BD	I	P	ID	IA	MF

EDI

David M. Garner, Ph. D.
Marion P. Olmsted, M.A.
Janet Polivy, Ph. D.

Name _____ Date March 1994

Age _____ Sex _____ Marital status _____

Present weight _____ Height _____

Highest past weight (excluding pregnancy) _____ (lbs)

How long ago? _____ (months)

How long did you weigh this weight? _____ (months)

Lowest past adult weight _____ (lbs)

How long ago? _____ (months)

How long did you weigh this weight? _____ (months)

What do you consider your ideal weight? _____ (lbs)

Age at which weight problems began (if any) _____

Present occupation _____

Father's occupation _____ Mother's occupation _____

PAR Psychological
Assessment
Resources, Inc.
P.O. Box 998 / Odessa, Florida 33556
Telephone (813) 968-3003

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9 8 7 6 5 4 3 2 1

Printed in the U.S.A.

This form is printed in blue ink on white paper. Any other version is unauthorized.

INSTRUCTIONS

This is a scale which measures a variety of attitudes, feelings and behaviors. Some of the items relate to food and eating. Others ask you about your feelings about yourself. THERE ARE NO RIGHT OR WRONG ANSWERS SO TRY VERY HARD TO BE COMPLETELY HONEST IN YOUR ANSWERS. RESULTS ARE COMPLETELY CONFIDENTIAL. Read each question and fill in the circle under the column which applies best to you. Please answer each question *very* carefully. Thank you.

	ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
1. I eat sweets and carbohydrates without feeling nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I think that my stomach is too big.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I wish that I could return to the security of childhood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
4. I eat when I am upset.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I stuff myself with food.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I wish that I could be younger.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
7. I think about dieting.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I get frightened when my feelings are too strong.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I think that my thighs are too large.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
10. I feel ineffective as a person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I feel extremely guilty after overeating.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I think that my stomach is just the right size.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Only outstanding performance is good enough in my family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. The happiest time in life is when you are a child.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I am open about my feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I am terrified of gaining weight.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I trust others.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I feel alone in the world.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I feel satisfied with the shape of my body.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I feel generally in control of things in my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I get confused about what emotion I am feeling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
22. I would rather be an adult than a child.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I can communicate with others easily.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I wish I were someone else.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
25. I exaggerate or magnify the importance of weight.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. I can clearly identify what emotion I am feeling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. I feel inadequate.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. I have gone on eating binges where I have felt that I could not stop.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
29. As a child, I tried very hard to avoid disappointing my parents and teachers.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. I have close relationships.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
31. I like the shape of my buttocks.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. I am preoccupied with the desire to be thinner.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. I don't know what's going on inside me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. I have trouble expressing my emotions to others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. The demands of adulthood are too great.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. I hate being less than best at things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. I feel secure about myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. I think about bingeing (over-eating).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
39. I feel happy that I am not a child anymore.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. I get confused as to whether or not I am hungry.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
41. I have a low opinion of myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
42. I feel that I can achieve my standards.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43. My parents have expected excellence of me.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44. I worry that my feelings will get out of control.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
45. I think that my hips are too big.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
46. I eat moderately in front of others and stuff myself when they're gone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
47. I feel bloated after eating a normal meal.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
48. I feel that people are happiest when they are children.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
49. If I gain a pound, I worry that I will keep gaining.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
50. I feel that I am a worthwhile person.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
51. When I am upset, I don't know if I am sad, frightened, or angry. .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
52. I feel that I must do things perfectly, or not do them at all.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
53. I have the thought of trying to vomit in order to lose weight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
55. I think that my thighs are just the right size.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
56. I feel empty inside (emotionally).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
57. I can talk about personal thoughts or feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
58. The best years of your life are when you become an adult.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
59. I think that my buttocks are too large.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
60. I have feelings that I can't quite identify.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
61. I eat or drink in secrecy.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
62. I think that my hips are just the right size.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
63. I have extremely high goals.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
64. When I am upset, I worry that I will start eating.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*

*

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7	2	3	2	6	2	4	1
DT	B	BD	I	P	ID	IA	MF

ROSENBERG SELF-ESTEEM QUESTIONNAIRE.

These are a series of statements about how you have felt about yourself. Please indicate your level of agreement with each statement by ticking the relevant box.

**1. I feel that I am a person of worth,
at least on an equal plane with others**

Strongly agree []
Agree []
Disagree []
Strongly disagree []

**2. I feel that I have a good number
of qualities.**

Strongly agree []
Agree []
Disagree []
Strongly disagree []

**3. All in all, I am inclined to feel
that I am a failure.**

Strongly agree []
Agree []
Disagree []
Strongly disagree []

**4. I am able to do things as well as
most other people.**

Strongly agree []
Agree []
Disagree []
Strongly disagree []

**5. I feel I do not have much to be
proud of.**

Strongly agree []
Agree []
Disagree []
Strongly disagree []

**6. I take a positive attitude towards
myself.**

Strongly agree []
Agree []
Disagree []
Strongly disagree []

**7. On the whole, I am satisfied with
myself.**

Strongly agree []
Agree []
Disagree []
Strongly disagree []

**8. I wish I could have more respect
for myself.**

Strongly agree []
Agree []
Disagree []
Strongly disagree []

9. I certainly feel useless at times.

Strongly agree []
Agree []
Disagree []
Strongly disagree []

**10. At times I think that I am no
good at all.**

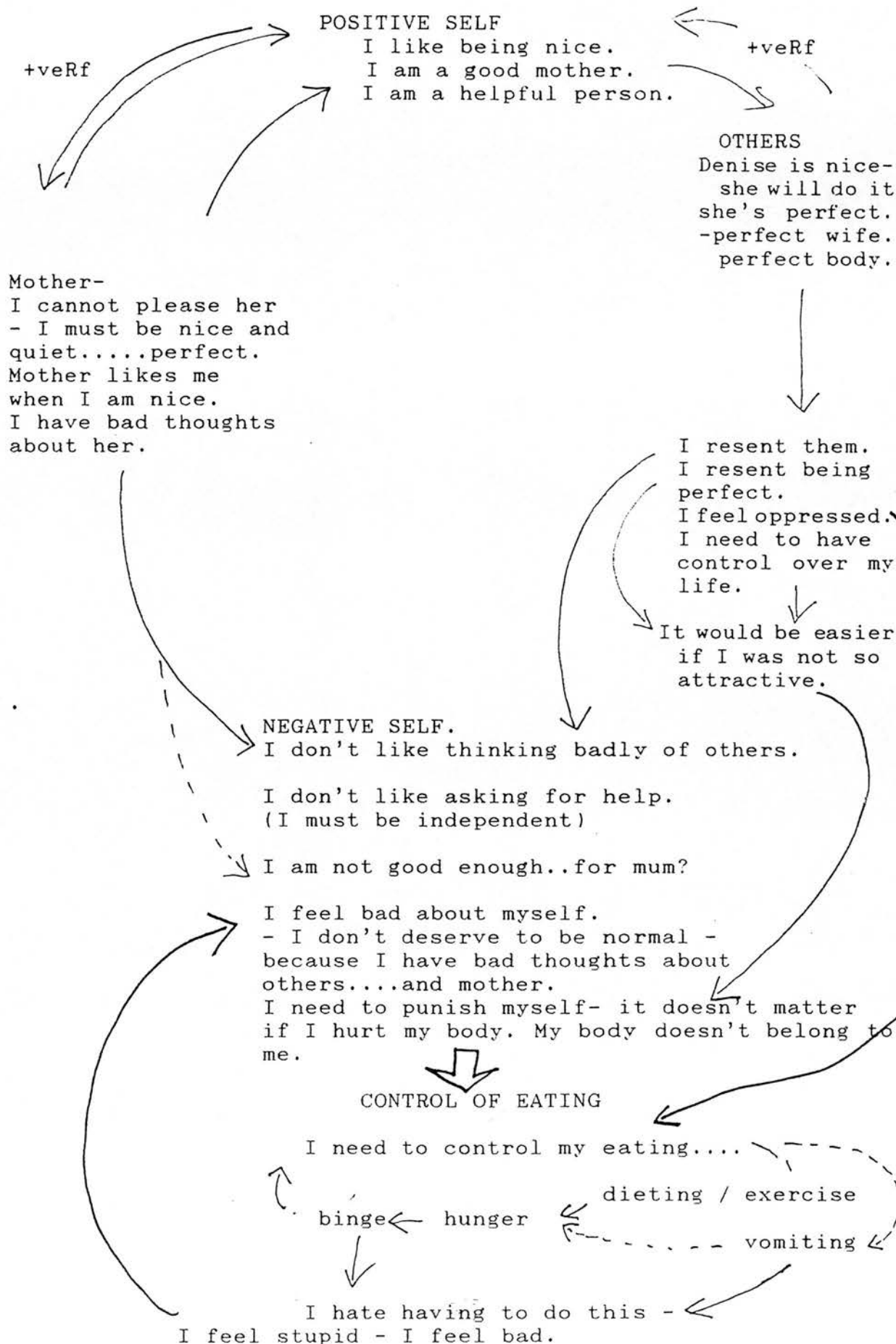
Strongly agree []
Agree []
Disagree []
Strongly disagree []

MCMASTERS FAMILY ASSESSMENT DEVICE (GENERAL FUNCTIONING SCALE)

3. Please indicate with a cross in the relevant box, how much you feel that the following statements apply to your family. By family I mean the family you grew up with i.e. parents, brothers, sisters etc.

	SD - Strongly Disagree		D - Disagree		A - Agree		SA - Strongly Agree	
	SD	D	A	SA	SD	D	A	SA
a) Planning family activities is difficult because we misunderstand each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
b) In times of crisis we can turn to each other for support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
c) We cannot talk to each other about the sadness we feel.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
d) Individuals are accepted for what they are.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
e) We avoid discussing our fears and concerns.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
f) We can express feelings to each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
g) There are lots of bad feelings in the family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
h) We feel accepted for what we are.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
i) Making decisions is a problem for our family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
j) We are able to make decisions about how to solve problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
k) We don't get along well together.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
l) We confide in each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

APPENDIX 3: BUZAN DIAGRAM.



APPENDIX 4: CORRESPONDENCE

DEPARTMENT OF CLINICAL PSYCHOLOGY

Ref: JI/MM
Tel: (0224) 663131
Ext: 57347
Fax No: (0224) 620740

Elmhill House
Cornhill Road
AB9 2ZY

IN CONFIDENCE

17 January 1994

Dr
Senior House Officer in Psychiatry to
Dr
Elmhill House
Roval Cornhill Hospital
ABERDEEN

Dear Dr Kemp

Re: _

Thank you for referring the above woman who was interviewed by Mrs Julie Wyness, Consultant Clinical Psychologist and myself on 25th November 1993. I have met with Mrs on a further three occasions to date.

You are aware of the presentation and background to Mrs eating disorder and I will therefore not reiterate the details here.

Currently Mrs is maintaining a weight of approximately 7st 3lbs through a variety of strategies including exercise and the occasional use of laxatives. Her preferred weight however is around 8 to 8½ stones and her inability to allow herself to gain weight is a continuing source of frustration and self approachment. Binge-eating and induced vomiting have not been a feature of her presentation over the last year although she did experience one episode in October 1993 and several episodes during the Christmas period.

Mrs describes her body image as shifting between "fat" and "thin" depending upon her mood and her environment. She feels less attractive being thin and is sensitive to comments made to her by others. She tends to avoid social eating and will be selective in wearing clothes to disguise her thinness in other social situations. Over the past year or so, she has at times felt very low in mood with poor self-esteem and feelings of hopelessness for the future. Currently her mood is at times dysphoric and she describes a general feeling of discontentment and unhappiness. She attributes such feelings to her problems with eating although she recognises other sources of frustration in her life - for example, her relationship with her mother has always been problematic and at work she finds that she is often taken for granted.

Mrs/

Mrs had initially described her upbringing as a happy one. On further reflection however, she has begun to recall unpleasant childhood memories of being bullied by her mother and feeling emotionally rejected. She is also beginning to understand the link between such dysfunctional parenting and her propensity to please others and avoid confrontation. Mrs describes herself as a conscientious and industrious person who strives for perfectionism in her private and working lives. Such traits appear to have been exploited both in her relationships with men (her ex husband and her ex boyfriend) and in her working environment, leading to feelings of oppression and anger. She acknowledges an inability to express such feelings and the apparent link between her suppression of emotion and a need to gain mastery over her life through weight control. There is evidence of a related dysfunctional belief system centred around the need to please others and to refrain from thinking badly about others' behaviours.

In summary, Mrs eating disorder appears to serve the function of control related to the suppression of emotion. This is a formulation which Mrs acknowledges and she has agreed to continue a counselling programme to explore this further. We have also agreed to look at alternative ways of thinking and behaving in situations which generate the need for control through dysfunctional eating.

I will also liaise with , Dietician , who is also assisting Mrs with her eating behaviour. Please do not hesitate to contact me should you require any further information.

Yours sincerely

Jim Isles
Trainee Clinical Psychologist

Mrs Julie Wyness
Consultant Clinical Psychologist

cc Dr

Surgey,

TEL: (0224)663131
EXT: 57219

ELMHILL HOUSE
CORNHILL ROAD
ABERDEEN
AB9 2ZH

REF: JI

DEPARTMENT OF CLINICAL PSYCHOLOGY

IN CONFIDENCE

Dr. .
Consultant Psychiatrist,
Elmhill House,
R.C.H.
Aberdeen.

15th April, 1994.

Dear Dr. .

Re:

Dr. . referred the above woman to this department on 22.6.93.
was subsequently interviewed by myself and Mrs. J.Wyness, Consultant Clinical
Psychologist on 25.11.93. I wrote to Dr Kemp concerning . presenting
eating disorder on 7.1.94.

Since initial interview, I have continued to meet with . on a regular
basis. She continues to maintain her weight at around 80% of her optimum
weight by restrictive diet and regular exercise. There has been no further
episodes of binge-eating /vomiting since January 1994. She remains
amenorrhagic.

It had become clear that . eating disorder is secondary to underlying
issues concerning her need to seek approval and the resulting conflict which
arises when her eagerness to please is abused. For example, in her
relationships with men she has been expected to be a perfect partner and
sexual object with subsequent feelings of oppression. In her work, she has
been expected to comply with excessive demands. Her need for approval stems
from childhood coping responses to emotional rejection from her mother. This
and related issues have been explored with . in a counselling programme.
She has also been engaged in cognitive-behavioural strategies to improve her
self esteem and self-efficacy. Currently she feels that she has made
considerable progress in resolving the reasons underpinning her eating
disorder. She now feels more ready to attempt weight restoration and has begun
a gradual increase in her dietary intake.

I am finishing my placement with this department and I have therefore arranged for . to be reviewed by Mrs. Wyness, who will be contacting you in due course.

Yours sincerely,

Jim Isles,
Trainee Clinical Psychologist.

cc Dr. .
Medical Practice,

TITLE: A CASE STUDY OF A CLIENT WITH A LEARNING
DISABILITY, REFERRED TO A CLINICAL PSYCHOLOGY
DEPARTMENT FOR PSYCHOLOGICAL ASSESSMENT AND
TREATMENT OF AN ANXIETY DISORDER.

JAMES I. ISLES

Submitted in part fulfilment of the degree of doctorate in Clinical Psychology
at the University of Edinburgh, February 2000

I certify that this report is a fair and accurate account of the work carried out.

Signed:

STELLA H. C. DONALDSON

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2,450 words (approx)

TITLE:

A case study of a client with a learning disability, referred to a Clinical Psychology department for psychological assessment and treatment of an anxiety disorder.

THE CLIENT:

Don is a 23 year old single man with a mild learning disability which was compounded by the sequelae of a head injury incurred at the age of 15 years. He suffers from epilepsy, memory dysfunction, mild left hemi-sensory loss and left homonymous hemianopsia. He lives at home with his parents and is employed in a sheltered workshop.

REASON FOR REFERRAL:

In late 1993, Don had began to experience an exarcebation of epilepsy which had hitherto been controlled by medication. At the same time he experienced an acute episode of panic disorder and had been referred indirectly to Clinical Psychology in early 1994.

ASSESSMENT:

Don presented on interview as a pleasant, friendly and socially skilled young man. He was accompanied by his mother who invariably answered questions for him, much to his apparent annoyance. His mother's presence at the interview however was necessary in light of Don's verbal memory impairment.

Several further interviews were carried out at Don's home and further assessment data was elicited through contact with staff at Don's sheltered workshop. The therapist also contacted those NHS professionals who were previously involved in his care.

Don described typical features of panic disorder - a high level of anxiety accompanied by strong somatic symptoms including palpitations, nausea, and sweating. He would respond to the urge to flee by escaping from the situation and thus experiencing symptom relief. (World Psychiatric Association, 1993)

At other times, he would experience symptoms of general anxiety with migraine, vomiting and irritable bowel.

In general, Don avoided situations which he thought may provoke panic with a degree of agoraphobia evident. He could not recall what thoughts passed through his mind during panic suggesting that his responses were automatic. Later analogue assessments (in vivo exposure) failed to determine a cognitive component to his panic experience.

Stimulus mapping (Thyer, 1987) suggested that the triggers for Don's panic included:

- a) situations of personal threat such as road crossing or the prodromal symptoms of epilepsy;
- b) unfamiliar environments and procedures, eg bus travel;
- c) situations of demand and evaluation;
- d) on being away from his parents overnight or experiencing uncertainty about their whereabouts.

Neither Don nor his mother were able to describe the frequency or duration of his panic attacks or were able to suggest modifying variables. His panic had become less marked at the time of initial interview, due to a review of his anti-convulsant medication and the absence of generalised seizures. His clinical features were however indicative of DSMIII Criteria for Panic Disorder with Agoraphobia.

PRECIPITATING FACTORS:

The abrupt change of Don's epileptic status from infrequent to almost daily episodes of tonic-clonic seizures had been very traumatic for him. He had surmised that he may have a brain tumour with subsequent anxiety. He had incurred seizures at his work and when on his own at a local shopping centre. Consequently he had been reluctant to venture from home unaccompanied and could not be left on his own without the reassurance of repeated telephone contact with his parents. Significantly perhaps, in late 1993; Don had been concerned about the health of his father after having found him in a state of collapse.

PHENOMENOLOGICAL DATA:

In general Don described himself as a happy and content person who appeared to have little understanding of the nature of his anxiety. He disclosed that he was afraid of having a further seizure and that his frequent epileptiform "sensations" were thus anxiety provoking. He still harboured a concern that he may have a brain tumour although his main fear was that his epilepsy may prevent him from returning to work. He was aware that his work placement had been compromised due to poor attendance and he had subsequently felt upset and angry. Clearly his work was central to his self-identity and esteem.

Don also felt sad at times when thinking that he may someday lose his parents. Such thoughts had generated onset insomnia over the past few years with occasional nightmares. He had continued to be concerned about his father's health and frequently worried about his mother, who had been ill with a biliary- hepatic tumour.

Such concerns appeared to be ruminative and may have been

triggered by media news of accidents or on hearing his parents openly discuss health matters - vicarious learning ? (Bandura, 1977) Don's fear of losing his parents may also have been compounded in his late teens by the accidental death of an aunt; which occurred whilst his parents were away overnight. Since then he had been unable to tolerate overnight separation from his parents.

On discussing the future, Don was aware that in the event of both his parents dying; either his older brother or his older sister, would provide care for him. However he believed that he would not be able to survive without his parents and in that event, stated that he would harm himself.

Don also expressed strong emotion when questioned about the pursuit of independent living, a sensitive issue for him given his apparent separation anxiety. He said that he was "fed up" being told by social workers that he should be more independent. It was therefore deemed prudent to state any psychological interventions in the form of short-term objectives.

DEVELOPMENTAL DATA:

As a young child Don was noted to be late in walking with problems of motor integration. He had also had problems with toilet training. At around the age of 2 to 3 years, Don had experienced night terrors culminating in episodes of mutism and the development of a stammer. At 4 years he had been hospitalised for repair of a hernia and right orchidectomy without apparent distress at being separated from his parents. However, separation anxiety was evident on entering nursery and primary school. At the age of 5 years, Don was extremely upset at the death of his paternal grandmother and had been preoccupied with the subject

of death and loss for sometime thereafter.

At primary school Don was subject to bullying and he had frequently attempted to run home. It was also noticed that he had learning difficulties and an Educational Psychologist became involved when Don was 8 years. At that time he was assessed as having an IQ of 86 (Stanford-Binet Scales). However, further testing revealed a poor ability in reading and numbers. Other features noted during testing ie poor visual discrimination, general clumsiness, poor attention (daydreaming) and poor hand control prompted the psychologist to seek a neurological assessment. However no organic pathology was determined and Don was subsequently referred to Child Psychiatry where he was given several sessions of psychotherapy and was noted to be more attentive at school.

Although Don could have been enrolled into mainstream secondary education, his parents preferred that he be placed in a special needs environment. Unfortunately, he was also bullied at this school and it was during an escape from bullying that he ran on to a road and was struck by a vehicle. The subsequent brain injury was marked by a prolonged period of unconsciousness and subsequent post traumatic confusion. His physical status however made a speedy recovery and he returned to his school after 6 months. Although registered as blind, Don had adapted to his visual impairment by scanning.

From ages 16-19, Don attended Adult Training Centres where he was involved in various social activities and had made friends (including a girlfriend) He had been able to travel independently on several occasions although he continued to have anxiety problems.

Don's ability at craftwork prompted his transfer to a Blindcraft workshop which proved to be too demanding for him. He experienced an episode of panic disorder and remained without a placement for 6 months when he was offered a workshop placement within walking distance of his home.

An interview with the manager of Don's workplace, revealed that he had initially done well with his work and was more able than the majority of trainees. However during the latter half of 1993, Don had began to have excessive absence from work and the continuation of his placement had therefore been under review.

BACKGROUND DATA:

Don's family had experienced considerable trauma in their lives and it was evident that Don's mother had played a pivotal role in maintaining family equilibrium. There was also evidence of mutual inter-dependency, which may in part be explained by his mother's disclosure that she had experienced an unhappy childhood. She presented as an over-powering individual who has clearly been assertive in pursuing Don's special needs. However, her use of language was often above the level of Don's understanding and he appeared therefore to 'switch off' during family discussions. In contrast, Don's father presented as a more reserved individual who is according to his wife; was prone to excessive worry and to "communication difficulties" with their children.

PREVIOUS INTERVENTIONS:

Don had received help with his anxiety disorder from various sources. However these interventions appeared to have been sporadic and unplanned, with marginal influence on his symptoms.

PSYCHOMETRIC ASSESSMENT:

Kadzin et al (1983) and Lindsay et al (1994) have demonstrated the viability of psychometric assessment of anxiety and other emotions in those with a learning disability. The following questionnaires were therefore administered to serve both as an adjunct to assessment and as a possible outcome measure:-

- 1) An adapted version of the Zung Self-rating Anxiety Scale (Lindsay and Michie, 1988, with further adaptations by the therapist) which produced a score of 60 (cut-off score = >45) and is therefore indicative of an anxiety disorder.
- 2) An adapted version of Foulds and Bedford DSSI/Anxiety and Depression scale (1978) which produced scores to confirm the presence of a dysthymic condition. (Appendix)
- 3) An adapted version of the Marks and Mathews (1979) Fear Questionnaire which confirmed Don's fear of specific situations and provided additional data on a wide range of fears. (Appendix)

OTHER ASSESSMENT:

- 1) Don was able to read analogue time although his numeracy and reading abilities were poor.
- 2) A battery of neuropsychological tests had been administered by a neuropsychologist in 1987 and in early 1994. The recent tests included the following :
 - a) Weschler Adult Intelligence Scale- Revised.
Verbal I.Q. 71. Performance I.Q. 63, Full Scale I.Q. 66
 - b) The Rey Auditory-verbal learning test which demonstrated a profound impairment in Don's verbal memory.

3) Diary keeping:

Due to Don's poor verbal memory, his mother had provided him with a dictaphone to record his therapeutic sessions for playback. He was also asked to keep an audiotape diary of anxiogenic and epileptiform experiences for further discussion.

HYPOTHESES:

The assessment gleaned from interviews with Don, his parents, workshop staff and other relevant NHS staff provided sufficient data to generate the following hypotheses:

Hypothesis 1:

That Don's experience of panic attacks is triggered by

- a) situations in which he experiences physical or psychological threat or demand.
- b) separation from his parents or thoughts that they be may be harmed.

Hypothesis 2:

That Don's recent episode of panic disorder was precipitated by the change in his epileptiform status and other significant life events.

Hypothesis 3:

That Don's anxiety disorder is maintained by habitual escape and avoidance which has failed to provide him with the opportunity to generate self-efficacy. (Bandura, 1989) This failure may be depressogenic and inhibiting in building self-esteem.

(Baumeister, 1993)

Hypothesis 4.

That underlying Don's trait anxiety and low self-efficacy is separation anxiety (Rank, 1936); and partial failure of the normal process of differentiation-individuation. (Symington, 1981)

Hypothesis 5.

That Don's separation anxiety is reinforced by mutual interdependency - the norm in this family and which may be the consequence of his parents' experiences of childhood and their possible feelings of guilt concerning Don's condition. (Wolfensberger, 1983; Stokes and Sinason, 1992)

Hypothesis 6:

That Don's trait anxiety reflects early experience of physical and emotional trauma. (Sinason, 1987; Hermann, 1992)

HYPOTHESES TESTING:

Hypotheses 1 to 3 were validated by further invivo exposure and through further discussions with both Don and his mother.

Hypotheses 4 and 5 were difficult to validate although they served as working hypotheses in understanding Don's anxiety behaviours and his poor exploratory behaviour.

In further discussion with his parents, they acknowledged that they have been overprotective with Don, especially since his head injury. They believed that they have done their best in facilitating Don's independence but had become weary because of his poor motivation and inter-related anxiety problem. Thus they attributed Don's anxiety disorder to intra-personal phenomena rather than to complex inter-dependency issues.

Hypothesis 6 was not pursued due to Don's poor memory recall.

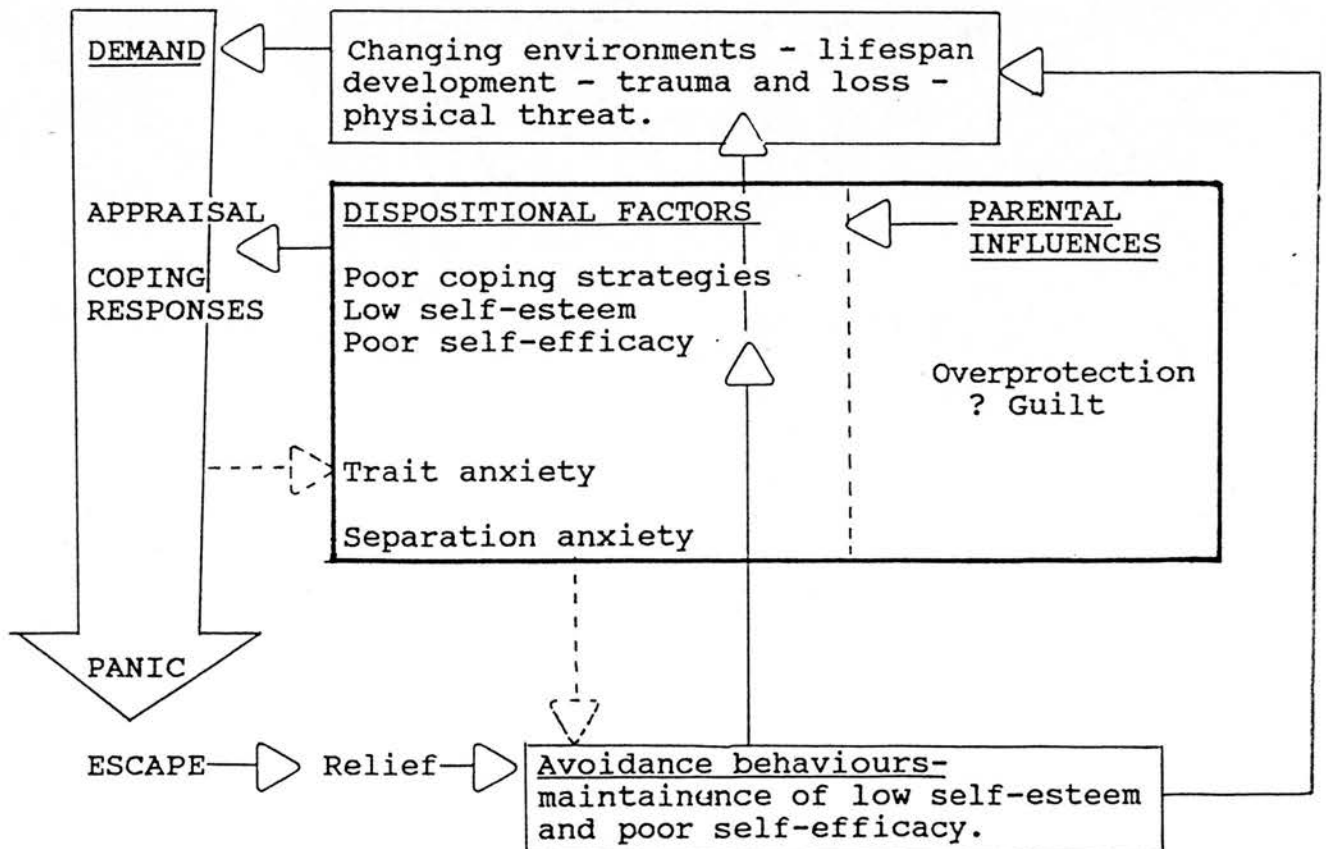
FORMULATION:

Don's anxiety disorder is maintained by his experience of the symptoms of anxiety and his lifelong habit of escape and avoidance strategies. Such responses to demand or threat have not allowed him the opportunity to develop a sense of mastery over his environment and thus develop self-efficacy.

His anxiety disorder is also a feature of trait anxiety, which has arisen from the childhood traumas of separation and physical threat. Both state and trait anxiety are compounded by parental over-protection and have inevitably led to separation anxiety and poor exploratory behaviour.

These processes were exacerbated by Don's experience of head injury at the age of 15 years. (Figure 1)

Figure 1: Diagrammatic representation of the Formulation.



PSYCHOLOGICAL INTERVENTIONS (SHORT-TERM):

The above formulation formed the basis of a programme of psychological interventions to assist Don in resolving his anxiety disorder:

1. A graded exposure programme to provide Don with the opportunity to build up confidence in managing threat and demand. (Lindsay, 1991):-
 - a) Road crossing (therapist assisted invivo exposure).
 - b) 'Home alone'- Don (and his parents) agreed that he would be left alone in their house for graded periods of time without reassurance.
 - c) A programme of exposure to bus travel. (Appendix)
2. Anxiety management training:
 - a) Don was taught cue-controlled relaxation to manage anxiety feelings and his experience of epileptiform sensations. (Wells et al, 1978; Lindsay, 1991)
 - b) Cognitive strategies - Don was encouraged through cognitive rehearsal to anticipate problems which may be encountered in exposure to new situations. (Meichenbaum, 1977)
 He was also encouraged to elicit anxiogenic thoughts which may be amenable to cognitive challenging. (Beck and Emery, 1985; Lindsay, 1991))
 Don was also encouraged to use audiotape feedback to catch fleeting thoughts and express confused emotion. (Williams and Moorey, 1987)
 - c) To aid Don's understanding of the nature of anxiety and its resolution, a metaphor was incorporated into a simple anxiety education programme. (McCurry and Hayes, 1992) This metaphor was based on the concept of a mischievous 'gremlin'

who derives enjoyment from watching people panic and flee!

3. Through individual counselling Don would be encouraged to verbalise his various fears and be helped to express and understand his confused emotions. (Bates, 1992; Conboy-Hill, 1992)
4. Through family counselling, Don's parents would be allowed to express their fears about Don and his future. Such discussion may also facilitate parental 'permission' and support for current and future therapeutic interventions. (Vetterre, 1993)
5. The therapist agreed to discuss relevant parts of this programme with Don's workshop manager and to assist staff in further management and understanding of Don's anxiety disorder.

PROGRESS AND EVALUATION (OCTOBER, 1994):

Don returned to work in mid-summer, his placement having been secured by the diplomacy of the therapist's supervisor (who has established a strong network of informal communication with other professionals). His work performance and attendance have been good, despite a recent relapse of his anxiety which was possibly due to therapist changeover; the demands of his bus travel exposure and problems with some of his co-trainees.

At home Don spent increasing periods of time alone without undue anxiety and recourse to telephone contact with his parents.

His road-crossing programme was completed although the advent of winter and darker nights may require further intervention.

Within-session levels of anxiety did not necessarily habituate although Don's overall anxiety level was reduced. (Figure 2)

The bus travel programme was implemented recently and is to be continued by another therapist. (figure 3)

FIG 2 : Self-report levels of anxiety during exposure to road crossing.

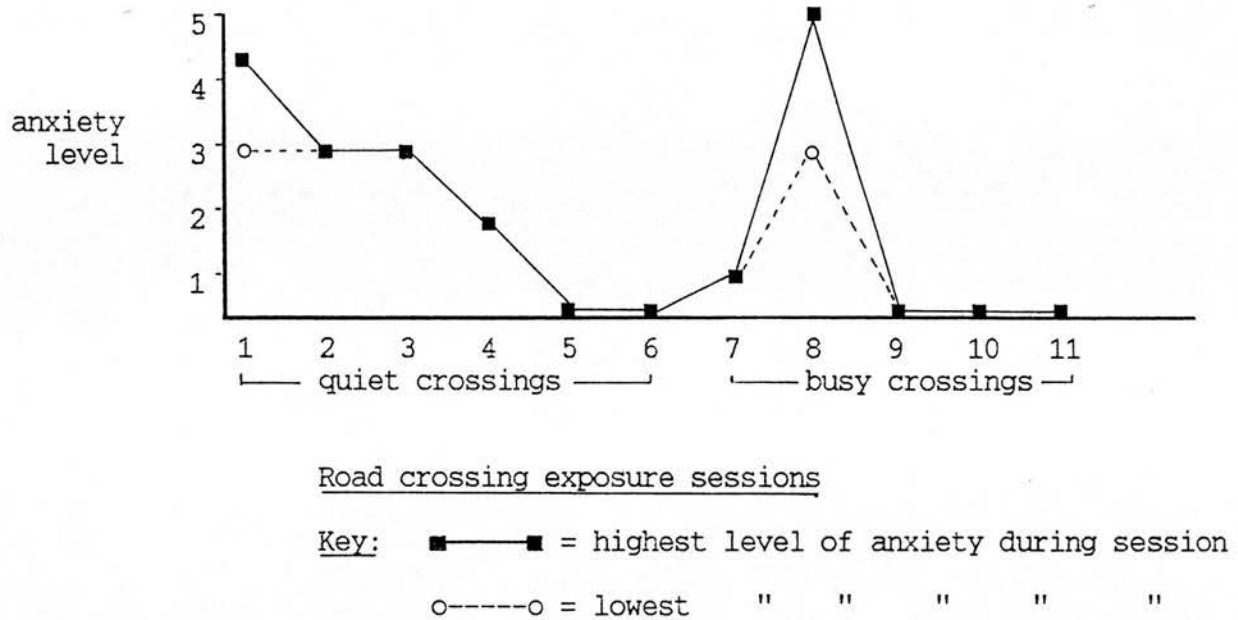
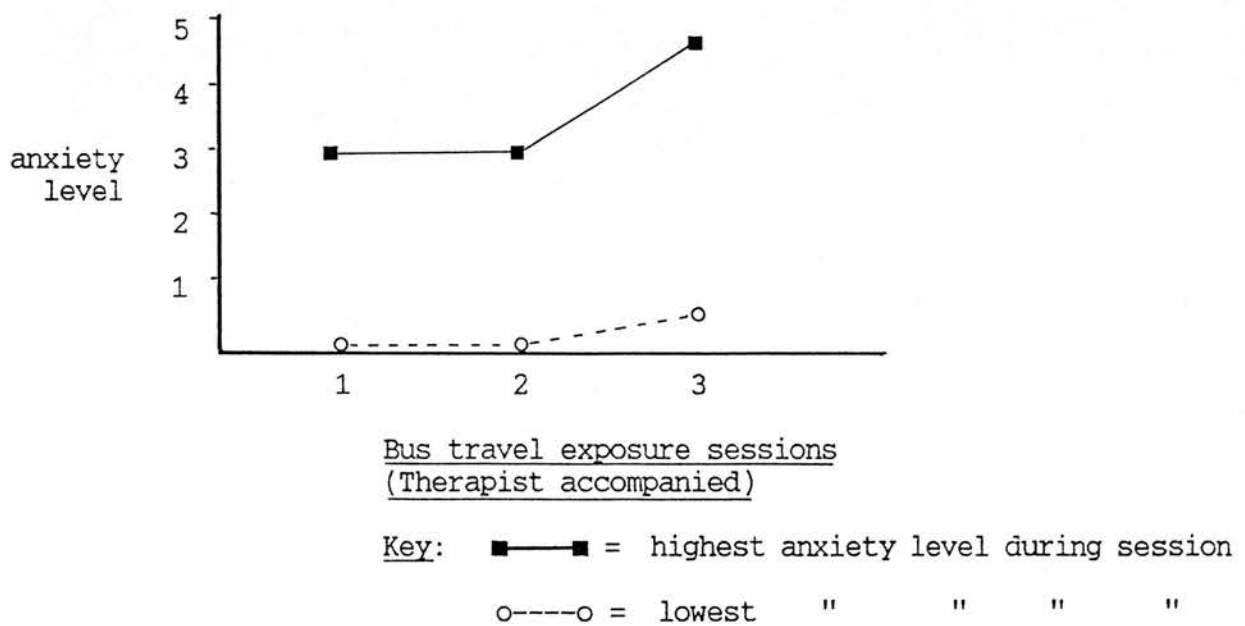


FIG3 : Self-report levels of anxiety during exposure to bus travel.



Don continues to experience frequent epileptiform phenomena although he no longer feels afraid of these "sensations". He reports that he practices cue-controlled relaxation although this has not been observed.

Don has at times felt frustrated with various issues and has used his audiotape to "sound off". Interestingly his anger was verbalised in the style of the 'Hollywood tough guy' genre. He has also found the gremlin to be a tangible concept in understanding his anxiety condition.

Don's parents have been encouraged by his progress and they had observed changes which suggest that he had benefited from individual counselling. They also reported having derived benefit from 'family counselling' and feel that they have a better understanding of Don's anxiety disorder.

The staff at Don's workshop now appear to be more aware of Don's difficulties and are in a better position to assist him with his anxiety symptoms.

PSYCHOMETRIC MEASURES IN EVALUATION:

Two pre-treatment questionnaires were repeated and the results indicate an improvement in Don's anxiety ratings and dysthymic state. It should be noted however, that the adaptations (albeit minor) made to these questionnaires may have effected validity and reliability. (Appendix)

		<u>Pre-treatment:</u>	<u>Outcome:</u>
Zung SAS	score=	60	23.5
		(Morbidity cut off score = >45).	
DSSI/sAD	score=		
	no. of symptoms	9	2
	severity	13	2
		(Morbidity cut off score= >4).	

SUMMARY:

This case study is a description of the assessment, formulation and short-term psychological interventions involved in assisting a client with an anxiety disorder. To date the interventions employed are having a marked effect on the client's anxiety condition. Further objectives, such as improving peer group contact may be made in the light of continuing progress. It is likely however, that this client will have major difficulties in resolving an underlying separation anxiety and he (and his parents) may therefore require assistance at various stages of his lifespan development. The Clinical Psychology department involved with this client appears to function as a life cycle service akin to that of General Practitioner services. Thus it is well geared to the needs of people with learning disabilities, in line with current trends towards providing brief psychotherapy and support at different stages of the life cycle. (Clarke and Clarke, 1985)

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GRAMPIAN HEALTHCARE
NATIONAL HEALTH SERVICE TRUST

2nd September, 1994.

51/pt

Dr *Services for People with a Mental Handicap*

Dear Dr

Re: ...DQN

Thank you for referring the above man, whom I interviewed on 4th July, 1994 under supervision of Mrs S. Donaldson, Consultant Clinical Psychologist. Mrs, Don's mother, was also present to assist him in describing the presenting problems of anxiety and panic attacks.

As you are aware, Don - is a 23 year old man with a mild learning disability, which is compounded by the sequelae of a head injury incurred in a road traffic accident in 1985. Don . now suffers a mild degree of left sided weakness; left homonymous hemianopsia, memory impairment and epilepsy. The latter had been controlled, until late 1993, when he began to have weekly episodes of Grand Mal seizure. Currently his epilepsy is more controlled, following initiation of a new drug regime (Carbamazepine) in June, 1994. Don! continues, however, to experience frequent brief episodes of an epileptiform nature; which he describes as similar to that of the prodromal symptoms of seizure. He was assessed by Mr....., Consultant Neuropsychologist in March, 1994 and is due to be reviewed by MrConsultant Neurosurgeon, in October.

On interview, Don presented as a socially skilled and pleasant man, who did not appear unduly anxious. He described having experienced intermittent panic attacks since childhood, which had become more marked since the relapse of his epilepsy. His panic is generally related to situations of psychological and physical threat. For example, when feeling under evaluation; when in unfamiliar surroundings; when separated from his parents (particularly overnight); when crossing busy roads and of course more recently when experiencing the prodromal symptoms of epilepsy.

At the height of panic, Don r experiences typical symptoms of panic disorder, including palpitations, sweating, nausea and a strong urge to flee. In general he escapes from situations in which he feels panicky and tends to avoid situations in which he anticipates further anxiety. Underlying his anxiety condition appears to be a lack of confidence and a marked separation anxiety concerning the loss of his parents. Until psychological input, Don was unable to be at home alone without reassurance of telephone contact. Similarly, he has been unable to stay away overnight without experiencing panic, triggered by thoughts that his parents may be harmed. Such thoughts are also triggered by television reports of accidents and may have been generated by the death of a close relative and earlier experiences of loss.

In general, Don . describes his mood as stable and content, although he does become easily frustrated when his needs are thwarted or when he is unable to accomplish a task. His sleep has been problematic due to onset insomnia involving thoughts of loss. Interestingly, he requires the comfort of a sleeping bag to feel safe in bed.

Woodlands Hospital, Craigton Road, Cults, Aberdeen, AB1 9PR
Tel: (0224) 663131 Fax: (0224) 663131 Ext: 51607

Don's joinery work at Crafts is central to his self identify. He had therefore been upset at the possibility of losing his placement, due both to his epilepsy and to an overall poor attendance record since commencement in October, 1992. Mrs Donaldson however, recently chaired a meeting with Don's parents and representatives of Crafts Workshop and for the meantime, his placement is secure. Copies of the minutes of this meeting are enclosed.

Although Don's social life revolves around his family, he appears to be content with limited peer contact. He has in the past attempted various social activities for disabled groups and has had girlfriends. However, he has been unable to sustain such activities, due to his panic symptoms and his inability to travel independently.

On a background note, you are aware that Don lives with his parents, both of whom acknowledge that they have been over protective with him, especially following his road traffic accident. Mrs in particular describes an interdependent relationship with Don and is aware that she has yet to resolve many of the emotions which were generated by his head injury. You are also aware that the family has experienced considerable trauma over the past two decades and not surprising, both parents are reticent about encouraging Don's independence. At the same time, they recognise their own need to be more independent from Don and they have been very supportive in my contact with him.

In summary, Don suffers from general anxiety and intermittent panic disorder. His panic is related to situations of personal threat and is maintained by the habits of escape and avoidance. His recent experience of Grand Mal epilepsy has compounded his symptoms and exacerbated his anxiety condition. Underlying his trait anxiety is low self esteem and a marked separation anxiety stemming from childhood experiences.

Since initial interview, I have continued to meet with Don and his parents on a regular basis. With the family's agreement, I have initiated an exposure programme to resolve Don's fear of road crossing and bus travel. I have introduced anxiety management strategies to help Don deal more effectively with the symptoms and to begin to tackle the fear of being separated from his parents. He clearly requires some life cycle training, although it would be prudent to delay such instructions until he has gained more confidence. To date, such approaches are proving of value to Don and he reports some progress. He is now able to stay at home alone without reassurance and he is now less concerned about the effects of his epileptiform sensations. He is back at work and appears to be coping with the demands of his work environment. His anxiety symptoms have reduced in frequency and intensity. Further progress is likely to be gradual given Don's memory impairment and his well-established practices of escape and avoidance.

I am due to finish my placement at Woodlands in late October, 1994 when Don's progress will be reviewed by Mrs Donaldson and further psychological input offered if necessary.

Yours sincerely

Jim Isles
Trainee Clinical Psychologist

Mrs Stella H.C. Donaldson
Consultant Clinical Psychologist

c.c. Mr
Dr

Consultant Neurosurgeon,

APPENDIX 2BUS TRAVEL EXPOSURE PROGRAMME.

1. Discuss / rehearse anticipated problems -

- a) asking the fare.
- b) asking driver to announce required stop.
- c) requesting stop - using bell.
- d) use of identity bracelet re possible epileptic seizure.
- e) dealing with the gremlin (panic).

2. Graded exposure -

- a) Bus from A. to B. and return.
(Accompanied - seat by seat, downstairs).
- b) Bus from A. to B. and return. (Accompanied - seat apart, downstairs)
- c) Bus from A. to B. and return. (Accompanied - Don downstairs, therapist upstairs).
- d) Repeat stage (c) excepting Don to travel to return bus stop unaccompanied. Shadowed by therapist to return bus stop.
- e) Repeat stage (d) excepting therapist to alight from bus several stops from A. ie return journey. (Don to be met if desired at A. bus stop.)
- f) Bus from A. to B. (Accompanied - Don downstairs, therapist upstairs) Don accompanied to return bus stop. Don to travel unaccompanied to A. ie return journey. Therapist to shadow bus by car.
- g) Don to be accompanied to bus stop at A Don to travel unaccompanied to B and be met at B bus-stop. Don to be accompanied to return bus stop. Don to travel unaccompanied to A. ie return journey. Therapist to shadow bus by car.
- h) Repeat stage (g) excepting Don to find his own way to return bus stop.
- i) Don to travel unaccompanied. Observed alighting from bus and walking to return bus stop. Return unaccompanied.
- j) Don to travel independently from A to B. and return.
- h) Introduce bus travel to other places in a graded manner.

Note: * Initial stages involve rehearsal of bus skills.

* Don may spend time at B. before returning to A.

* Any of the above stages may be repeated for consolidation.

APPENDIX 3

ZUNG SELF-RATING ANXIETY SCALE (ADAPTED BY
LINDSAY & MICHIE, 1988 & WITH MINOR ADAPTATIONS
BY THE THERAPIST)

This scale is presented to the client verbally and in conjunction with a visual analogue scale representing the following responses:

None or a little of the time.
Some of the time/sometimes.
Quite a lot of the time.
Most of the time.

In the past week:-

1. Do you feel more nervous and anxious than usual?

Supplementary- Do you feel more jumpy or shaky than usual - do you feel your tummy nervous and upset?

2. Do you feel afraid for no reason at all?

3. Do you get upset easily or panicky?

4. Do you feel you are falling apart and going to pieces?

Supplementary - Do you feel that everything is going wrong and there is nothing that you can do about it?
Do you feel that you can't cope/carry on with things anymore?

5. Do you feel that evrything is alright and nothing bad will happen?

Supplementary - Do you worry in case anything terrible might happen, do you feel that everything is going to be fine?

6. Do your arms and legs shake and tremble?

Supplementary question added by therapist - Do your arms and legs shake and tremble when you are not having a fit?

7. Are you bothered by headaches, neck and back pains?

Supplementary - Are you bothered by a sore head, a sore neck or a sore back?

8. Do you feel weak and get tired easily?

9. Do you feel calm and can you sit still easily?

10. Can you feel your heart beating fast?

11. Are you bothered by dizzy spells?

12. Do you have fainting spells or feel like it?

Supplementary - Do you feel you are going to fall down because you are weak and dizzy?

Alternative question added by therapist - Do you feel faint at times when you do not have your (epileptic) sensations?

13. Can you breathe in and out easily.

14. Do you get feelings of numbness and tingling in your fingers and toes?

Supplementary - Do you ever get pins and needles in your fingers and toes, do you ever get any funny feelings in your fingers and your toes?

Alternative question added by therapist - Do you ever get pins and needles in your fingers and your toes at times when you have not been sitting on them/ when you are not having your (epileptic) sensations.

15. Are you bothered by stomach aches and indigestion?

Supplementary -Are you bothered by a sore stomach, do you ever get a burning feeling in the middle of your chest?

16. Do you have to empty your bladder often?

Supplementary -do you have to go to the toilet to pee a lot?

17. Are your hands usually dry and warm?

18. Does your face get hot and go red?

19. Do you fall asleep easily and get a good nights rest?

20. Do you have nightmares?

Supplementary - Do you have bad/frightening dreams.

APPENDIX 4 MARKS AND MATHEWS FEAR QUESTIONNAIRE (WITH MINOR ADAPTATION BY THERAPIST).

This scale is presented verbally to the client in conjunction with a visual analogue scale. The response scale is:

0	1	2	3	4	5
Wouldn't avoid it	Slightly avoid it	Definitely avoid it	Nearly always	Always avoid it	

Injectons (with needles).					2...
Eating or drinking with other people.					0...
Hospitals.					5...
Travelling alone by bus.				5...	
Walking alone in busy streets.				2...	
Being watched or stared at when doing something.					2...
Going into busy shops (where there are crowds).				5...	
Talking to people who are bosses or who seem to be important people.					2...
Sight of blood.					2...
Being criticised.					2...
Going away from home with your parents.				1...	
Going away from home without your parents.				5...	
Having thoughts of injury or illness.					2...
Speaking in front of a large audience.					5...
large open spaces - such as a park.					2...
Going to the dentist.					2...

Any other situation that you are afraid of
- that you may avoid if possible?
Please rate as above.

Ag Bl Soc
18 15 11
- 1

..... Escalators/Lifts 3

October 1994



1. Recently I have worried about every little thing.

False

True

If true, this has upset me:

A bit

A lot

Unbearably

2. Recently I have been so miserable that I have had difficulty with my sleep.
(so down in the dumps)

False

True

If true, this has upset me:

Unbearably

A lot

A bit

3. Recently I have been breathless or had a pounding of my heart.

False

True

(out of breath) (feel my heart beating very fast when I am not running...)

If true, this has upset me:

A bit

A lot

Unbearably

4. Recently I have been so 'worked up' that I couldn't sit still.

False

True

If true, this has upset me:

Unbearably

A lot

A bit

5. Recently I have been depressed without knowing why. (so down in the dumps)

False

True

If true, how depressed?

Fairly

Very

Extremely

6. Recently I have gone to bed not caring if I never woke up.

False

True

If true, how serious was this?

Desperately

Very

Fairly

7. Recently, for no good reason, I have had feelings of panic. (sudden feeling of fear)

False

True

If true, this has upset me:

A bit

A lot

Unbearably

8. Recently, I have ^(so down in the dumps) been so low in spirits that I have sat for ages doing absolutely nothing.

False

True

If true, this has upset me:

Unbearably

A lot

A bit

9. Recently I have had a pain or tense feeling in my neck or head.

False

True

If true, this has upset me:

A bit

A lot

Unbearably

10. Recently the future has ^(thinking away ahead) seemed hopeless.

False

True

If true, how hopeless?

Completely

Very

A bit

11. Recently worrying has kept me awake at night.

False

True

If true, this has upset me:

A bit

A lot

Unbearably

12. Recently I have lost interest in just about everything.

False

True

If true, how much loss?

Complete

A lot

A bit

13. Recently I have ^(more jumpy or shaky than usual) been so anxious that I couldn't make up my mind about the simplest thing.

False

True

If true, how anxious?

Fairly

Very

Extremely

14. Recently I have ^(so down in the dumps - so sad, hurt) been so depressed that I have thought of doing away with myself.

False

True

If true, how seriously?

Completely

Very

Not very

SCORES:pre.

July 1994

outcome

October 1994

Anxiety - number of symptoms
severity

5

2

9

2

Depression - number of symptoms
severity

4

0

4

0

Dysthymia - number of symptoms
severity

9

2

13

2

TITLE: A PILOT STUDY OF DIFFERENCES BETWEEN GENERAL
PRACTITIONER PRIORITY AND NON-PRIORITY REFERRALS
TO A CLINICAL PSYCHOLOGY DEPARTMENT.

JAMES I. ISLES

Submitted in part fulfilment of the degree of doctorate in Clinical Psychology
at the University of Edinburgh, February 2000

I certify that this report is a fair and accurate account of the work carried out.

Signed:

JULIE WYNESS

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ABSTRACT:

The management of Clinical Psychology waiting lists has been a recurrent theme in the brief history of the professions service to General Practitioners. The nature and validity of priority referrals has however seldom been questioned in the literature. This retrospective study therefore examines differences between General Practitioner samples of priority and non-priority referrals. The results suggest that priority referrals, whilst predicated on the basis of client need; may actually be a feature of inadequate General Practitioner assessment of need or other General Practitioner referral behaviours.

TITLE:

A pilot study exploring the differences between General Practitioner priority and non-priority referrals to a Clinical Psychology Department.

INTRODUCTION:

The effective management of Clinical Psychology waiting lists has been a recurrent concern in the development of services to General Practitioners. (Newnes, 1988, 1993) Inevitably, demand has exceeded the profession's capacity to provide a service which offers consistent and reasonable periods of waiting.

(McPherson and Felland, 1987; Newnes, 1988) Whilst it may be argued that the main focus within Clinical Psychology has been the provision of a reliable service; it is not clear to what extent the profession has successfully addressed the issue of responsiveness - the provision of a speedy and consumer-friendly service. (Zeithmal et al, 1990 - cited by Dickens, 1994)

The current emphasis within the NHS to decrease overall waiting list periods however, does require that Clinical Psychology gives priority to this important dimension of service quality.

The Division of Clinical Psychology's (1993) survey of a sample of Clinical Psychology waiting lists in 1992 suggests that responsiveness is yet to be realised. The DCP survey revealed that over ten thousand customers' had been waiting for an appointment in 1992; 64.7% of whom had been waiting for services

from Adult Mental Health Departments.

In the DCP's survey, the data for waiting list periods was incomplete with some departments operating a screening service and others reporting that they did not have a waiting list. However, for routine referrals, the DCP (1993) estimated that 44.2% of all consumers referred to Clinical Psychology will have been referred to a department with a waiting period of over 6 months. Further, 15% will have been referred to a department with a waiting period of over one year (DCP, 1993). Startup (1994) has projected from these figures to suggest that over 28,000 people may be currently waiting for an appointment with a Clinical Psychologist. By current NHS waiting list standards, such poor responsiveness may be deemed to be unacceptable. For example, Bucknall (1994) in describing the results of a client satisfaction study of a Clinical Psychology service; reports that 70% of respondents believed that a waiting period of around seven weeks was satisfactory. Bucknall (1994) suggests therefore, that a target waiting period of 6-8 weeks would be a reasonable measure of service quality. Such a target however may be difficult to obtain for those Clinical Psychology departments with insufficient staffing levels and/or difficulties with recruitment. The traditional solution for resolving the resource problem has been to advocate increased numbers of places available for Clinical Psychology training. (Kats, 1993). A more short term measure however was identified by the National Scientific Consultative Committee (1989); which reported that the commonest method of resolving demand for services was to close waiting lists. The DCP (1993) survey also revealed that Clinical

Psychologists were resorting to perhaps unsatisfactory methods in dealing with prolonged waiting lists. For example -

1. The use of restrictive practices such as discouraging referrals or operating strict referral criteria and closing waiting lists.
2. The use of groupwork.
3. The referral on to other professionals.
4. The use of restrictive treatment practices such as intermittent appointments or brief therapeutic interventions. (Barkham and Shapiro, 1989; Barkham et al, 1992; Blakey et al, in press).
5. Opting in / opting out measures.

Other suggested approaches have been to continue to train other professionals (Startup, 1994) or to select only the most serious and complex cases for intervention; leaving G.P.'s or counsellors to deal with milder cases. (Milne and Souter, 1988, Startup, 1994).

Some of the above measures may indeed meet the criteria for responsiveness in service quality, although arguably at the expense of reliability. Further, as Startup (1994) suggests, such approaches are likely to be of an avoidance nature rather than resolution strategies.

Of course waiting lists are also managed by external influences, for example the referring behaviours of General Practitioners who may reduce referral rates to Clinical psychology when waiting periods are long, or may redirect clients inappropriately to Psychiatry and other agencies. (Startup. 1994; Heller, 1994)

A dimension to waiting list management which has been given little attention in the literature is the appropriateness or

inappropriateness of priority referrals. Urgent referrals may consume considerable resources when managed by duty rotas and of course may extend waiting lists. Intuitively, it would be expected that urgent referrals either demonstrate increased levels of distress or increased life impairment when compared with non-priority referrals. However empirical evidence suggests that in many cases this difference is not established at clinical interview. This would suggest that General Practitioner's are referring some priority cases on a basis other than client need. If it were to be established that priority cases are indeed not dissimilar to non-priority cases, then there would clearly be considerable implications for the management of waiting lists. It is perhaps timely therefore to investigate whether priority referrals do differ from non-priority on indices such as symptomatology and life impairment.

AIM:

The aim of this study therefore is to pilot an investigation into whether or not there are actual differences between General Practitioner (G.P.) priority and non-priority referrals . The following hypotheses were tested to meet this aim:-

HYPOTHESIS 1:

That G.P. referral letters which have requested an urgent appointment, will be found to differ from non-priority referral letters in demonstrating more of the characteristics of referral urgency (as defined by a research proforma). If confirmed, this would suggest that G.P.'s are referring priority cases on a needs-assessment basis.

HYPOTHESIS 2:

That clients referred by G.P.'s as requiring priority will be found to differ from non-priority referrals on a pre-contact questionnaire measure of symptom level and life interference. A significant difference between the two groups in the direction of the priority group will provide further evidence that priority clients are indeed referred on the basis of need.

SUPPLEMENTARY HYPOTHESIS:

That priority referrals will be found to be proportionately represented between G.P.practices, thus reflecting universality of need.

METHOD:Hypothesis 1:

A random sample of 20 G.P. Priority referral letters was compared with a random sample of 20 G.P. non-priority letters for the presence of at least one of the following eight characteristics of referral urgency (As defined by a research proforma produced by Hamilton et al 1994):-

The client is in danger of:-

1. losing job, dropping out of study.
 2. relationship breaking down.
 3. harming self or others.
 4. financial difficulties.
- and/or
5. recent disclosure of traumatic events.
 6. problems are likely to significantly deteriorate.
 7. G.P. wants early advice about client's difficulties.
 8. other reason (stated).

A clinical psychologist also rated the samples to yield an inter-rater reliability of 100% for those letters found to have at least one urgency characteristic. A 94% inter-rater reliability was demonstrated for the individual urgency characteristics found in any letter.

Hypothesis 2:

Random samples of 85 priority referrals and 86 non-priority referrals were extracted from the Clinical Psychology (Adult Mental Health) Department's database. Due to missing data, a sample of 43 priority referrals was compared with a sample of 45 non-priority referrals on measures derived from a pre-contact Patient Questionnaire' (Baker and McFadyen, 1988-Appendix).

A sample of 77 priority referrals and 87 non-priority referrals from the original sample was also compared from measures derived from the combination of two subscales of the Patient Questionnaire (representing anxiety and depression).

The Patient Questionnaire is a shortened version of the Bedford and Foulds, DSSI (R)(Delusions-Symptoms-States-Inventory) which contains 7 subscales of 7 items each measuring the following: anxiety state, conversion symptoms, obsessional symptoms, depressive state, phobic symptoms, intrusive thinking and dissociative symptoms. The subscales of anxiety and depression represent the Foulds and Bedford DSSI/SAD which is deemed to measure dysthymic state. The other subscales represent the DSSI/NS (R) (Neurotic Symptoms).

The pre-contact 'Patient Questionnaire' includes Watson and Marks's (1971) Life Impairment Scale.

The Patient Questionnaire is a self-report questionnaire which

is sent out to clients along with an appointment letter. The questionnaire assesses whether or not each symptom has occurred within the previous 2-3 weeks (true-false distinction) and at what level of severity (A bit-A lot-Unbearably). A cut-off score of 4 is regarded as dysfunctional for both the number and the severity of symptoms.

The Life Impairment Scale is an 8-point Lickert self-report measure of life interference on the following:-

1. social leisure activities.
2. private leisure activities.
3. family leisure activities.
4. work.
5. home management.
6. sexual relations.

There is no morbidity cut-off score on the Life Impairment Scale. (Baker et al, 1993).

The samples of priority and non-priority referrals were analysed for statistical significance between means. (Two-tailed T-test, following Parry, 1989)

Supplementary Hypothesis:

The numbers of G.P. referrals to Clinical Psychology (Adult Mental health) in 1992 were examined to yield:-

- a) The total number of priority referrals for each G.P. practice.
- b) The proportion of priority to non-priority referrals for each practice.

Individual G.P. practice priority referrals were compared with an expected referral ratio of priority:non-priority of 1:4.

RESULTS:Hypothesis 1:

TABLE 1	NO. OF REFERRAL LETTERS DEMONSTRATING AT LEAST ONE CHARACTERISTIC OF URGENCY.
	No. of letters with urgent characteristics.
Sample 1: Priority letters (n=20)	= 17 (85%)
Sample 2: Non-priority letters (n=20)	= 5 (25%)

As Table 1 above shows, priority letters were found to differ from non-priority letters in demonstrating more of the characteristics of referral urgency. The difference is very highly significant at $p=0.001$ ($df=1$, $X^2= 14.54$). The null hypothesis is therefore rejected.

It is worth noting that 15% of priority referrals did not demonstrate at least one characteristic of referral urgency.

Hypothesis 2:

The results show that the means for the number of symptoms and for the severity of symptoms is higher for the priority group on 5 of the 7 subscales of the Patient Questionnaire:-

conversion, obsession, depression, ruminative and dissociation.

However the means for the priority group are lower for anxiety and phobic sub-scales. The morbidity cut-off score of 4 is reached by both groups on severity of anxiety and severity of depression; and in the non-priority group for number of anxiety symptoms. The differences between groups are however non-significant. (Table 2)

TABLE 2		DIFFERENCES BETWEEN PRIORITY AND NON-PRIORITY GROUPS ON MEASURES OF SYMPTOMATOLOGY (PATIENT QUESTIONNAIRE)		
SUBSCALE		PRIORITY (n=43)	NON-PRIORITY (n=45)	P-LEVEL
Anxiety	- number	3.67	4.18	0.263
	- severity	6.37	7.09	0.476
Conversion	- number	0.88	0.71	0.483
	- severity	1.42	1.16	0.543
Obsession	- number	1.44	1.13	0.300
	- severity	2.14	1.56	0.270
Depression	- number	3.72	3.42	0.544
	- severity	6.56	5.29	0.220
Phobia	- number	1.19	1.24	0.822
	- severity	1.93	1.96	0.958
Rumination	- number	2.37	1.67	0.134
	- severity	3.72	2.84	0.278
Dissociation	- number	0.72	0.67	0.785
	- severity	1.62	1.13	0.937

When the anxiety and depression subscales are combined however (the DSSI SAD scale for dysthymia), the means for symptom number and severity are higher in the priority group and almost attain statistical significance for symptom severity ($p=0.051$, $t=1.965$, $df=$) (Table 3.)

TABLE 3		DIFFERENCES BETWEEN PRIORITY AND NON-PRIORITY GROUPS ON THE DYSTHYMIC SUBSCALE OF THE PATIENT QUESTIONNAIRE.		
SUBSCALE:		PRIORITY (n=77)	NON-PRIORITY (n=87)	P-LEVEL
Dysthymia	- number	8.01	6.90	0.084
	- severity	13.71	11.13	0.051

On the Life Impairment Scale, the means for the Priority group are higher on the following:-

work, home management, private leisure activities, family leisure activities and sexual relations. The means for the priority group are however lower than the non-priority group for social leisure activities.

The differences between groups on the Life Impairment Scale fail to reach statistical significance. (Table 4)

TABLE 4	DIFFERENCES BETWEEN PRIORITY AND NON-PRIORITY GROUPS ON THE LIFE IMPAIRMENT SCALE.		
SCALE	PRIORITY	NON-PRIORITY	p-LEVEL
Work	2.93	2.07	0.094
Home management	2.23	2.11	0.799
Social leisure	2.90	3.53	0.216
Private leisure	2.09	1.76	0.497
Family relationships	3.40	3.29	0.839
Sexual relations	3.62	3.36	0.675

The failure to attain statistical significance between groups on measures of symptom level and life impairment leads to the acceptance of the null hypothesis. (Refer Appendix for full details of statistical analysis).

Supplementary Hypothesis:

Table 5 shows that in 1992, 38.5% of G.P. practices in Grampian referred zero priority referrals; 30.7% referred 1-2 priority referrals; 25% referred 3-6 priority referrals and a small number

of practices, 5.1% referred 9-12 priority referrals.

TABLE 5		NUMBER OF PRIORITY REFERRALS AS A PERCENTAGE OF G.P. PRACTICES.	
		% OF G.P. PRACTICES. $n = 78$	NO. OF PRIORITY REFERRALS. $n = 162$
		38.5%	0
		30.7%	1-2
		12.8%	3-4
	25%	12.8%	5-6
		0.0%	7-8
		3.8%	9-10
	5.1%	1.3%	11-12
		0.0%	>12
			3-6
			9-12

An analysis of the proportion of priority to non-priority referrals reveals that only 10.3% of practices referred within 2 standard errors (s.e.proportion= 4.2 at 99% confidence interval) of an expected referral rate of 1:4 (priority:non-priority). Thus 89.7% of practices referred outwith 2 s.e., 14% of which referred priority referrals above the expected referral rate. This evidence suggests that priority referrals are disproportionately represented amongst G.P. practices. The stated hypothesis is therefore rejected.

DISCUSSION:

This study confirms the hypothesis that G.P. priority referral letters differ from G.P. non-Priority letters in demonstrating more of the characteristics of referral urgency. This difference is found to be statistically significant.

Although the samples are small and failed to control for demographic variables or G.P. practice referral behaviours; the results do provide some evidence for the belief that G.P.'s are

referring priority cases based upon an assessment of urgency in client need. That 15% of priority referral letters did not however demonstrate characteristics of urgency, suggests that some priority cases are being referred on either a non-needs basis or through poor assessment of need.

The second part of this study set out to determine whether or not client need is reflected by differences between priority and non-priority referrals in measures of symptomatology and life impairment. Overall, the results do demonstrate that priority clients report greater levels of symptomatology and life impairment than non-priority clients. However this difference is not statistically significant and the results do therefore raise questions about G.P.'s assessment of psychological problems and inappropriate referring behaviours.

Blakey et al (1989) and Walker (1993) in studies of G.P. ratings for the presence of psychological symptoms during consultation, found a broad agreement between G.P. ratings and the independent ratings of a shadowing Clinical Psychologist. However in Blakey et al's (1989) study, there was considerably less agreement on whether or not psychological intervention would be appropriate and effective. This evidence does suggest that G.P.'s may be making referral decisions based upon poor knowledge of psychological interventions. In an earlier study on the influence of Clinical Psychology attachments to G.P.practices, Blakey et al (1987) found that the on-site presence of a Clinical Psychologist increased G.P.'s ability to discriminate between appropriate and inappropriate referrals to clinical psychology. The present study failed to control for those G.P. practices which had Clinical Psychologist attachments; and who may

therefore have referred priority referrals more appropriately. This study has also illustrated that large sample numbers may be required to attain statistical significance between the groups measured. When larger samples of Priority and Non-Priority client groups were compared in this study on the Foulds and Bedford's SAD dysthymia scale; the differences between the groups almost attained statistical significance ($p = 0.051$ in the direction of the priority group). Therefore, the non-significant results may be due to insufficient sample size.

The lack of statistical significance between the groups in this study may also be attributed to other factors; for example underscoring by the priority group. There is some empirical evidence that clients report feeling better by virtue of having received an appointment with a clinical psychologist. (Charlton, 1994 - personal communication). However, it would be expected that non-priority clients who may have had to wait for up to 9 months for an appointment, would respond in a similar manner. These are interesting variables which may not easily be controlled for in a larger scale study. It may also be the case that clients who have had to wait for extended periods of time experience spontaneous remission and thus report lesser levels of symptoms. However, Blakey et al (1994) found in a brief intervention study, that the levels of symptomatology and life impairment measured by the Patient Questionnaire, had not improved in the waiting list control group after 9 months. Further, no significant differences were found between the groups in terms of G.P. appointments and pharmacological prescriptions prior to first appointment.

The supplementary hypothesis tested in this study; that G.P.

priority referrals will be found to be proportionately represented among practices was not upheld. That the vast majority of G.P. practices (86%) under-refer priority cases (with over a third of practices referring zero cases); may suggest that there is little need for priority in referrals to Clinical Psychology. Alternatively, it may be the case that the needs of individuals with psychological distress are not being fully met. That 14% of practices did refer priority cases higher than the expected ratio, may reflect actual client need or is a function of G.P. referring behaviours.

Of course as Crump et al (1991) notes, the referral patterns of individual G.P. practices are unlikely to remain stable over short periods of time. Indeed the referral rates to Grampian Adult Clinical Psychology in 1993 were considerably reduced from 1:4 to 1:7 for priority:non-priority cases. This change may have been due to the overall decrease in waiting times effected by a change to patch-based services. (Blakey and Mcfadyen, 1992). It may be appropriate therefore to scrutinise G.P. referral rates over a number of years to determine changing patterns of referral behaviours.

Another confounding variable for this study has been the possible influence of fundholding in Grampian; the first wave of which was initiated in October, 1991. Although Healy and Reid (1994) found no evidence of increased referrals to specialities from G.P. fundholding practices, it may be the case that priority referral rates were indeed influenced by the fundholding process. G.P. referral patterns may also be influenced by a host of demographic variables and the clinical presentation of particular psychological problems. For example, in 1992, the male to female

ratio for G.P. priority referrals was 1:1.3 compared with a non-priority referral ratio of 1:2. Although no significant differences were found between males and females in this study on referral urgency, symptom level and life impairment (Appendix) clearly females are over-represented in all referral patterns. This may of course reflect actual need; differences in the help-seeking behaviours of males and females; or G.P. referring behaviours. The presentation of particular psychological problems may also influence priority referrals. For example, sexual abuse as an initial formulation category, accounted for 10.5% of all G.P. referrals to Clinical Psychology (Adult Mental health) in 1992. However, 50% of those referrals were on a priority basis and accounted for 22% of priority referrals. This figure may reflect actual need; G.P.'s perception of need or G.P.'s responses to the disclosure of traumatic autobiographical material.

It would be useful therefore to establish the effects of such problem areas on G.P. assessment of need and subsequent reason for priority referral. It would be possible to compare this problem type with other clinical formulations on symptomatology level and life impairment.

REPLICATION:

All the elements of this study could easily be replicated with the following methodological improvements:

1. Larger samples of G.P. priority and non-priority referral letters could be scrutinised for the characteristics of referral urgency. At least one priority and one non-priority

letter could be randomly selected from each G.P practice to ensure representation of all practices. Comparisons could also be made between high and low G.P. priority referrers and demographic variables such as gender and geographical location. The influence of those practices having or having had a Clinical Psychology attachment could be controlled for by exclusion. Inter-rater reliability could be made more valid by rating letters blind and by using Cohen's Kappa test for inter-rater reliability. (Howell,1992)

2. Larger samples of G.P. priority and non-priority referrals, could be selected from all practices in Grampian or alternatively, practices which have high and low priority referring rates. The Patient Questionnaire could be used to measure differences in symptomatology and life interference. The study could control for variables such as age, gender and socio-economic class. G.P.'s having had or currently have a Clinical Psychology attachment could be excluded or compared as a separate group. To control for possible waiting list response variables, the Patient Questionnaire could be sent out to both client groups with a letter of acknowledgement requesting speedy questionnaire return. This letter would also indicate that a further letter was in post which would intimate to the client the relevant waiting period - either an immediate appointment or waiting list appointment. The Patient Questionnaire would be repeated at the time of appointment for the non-priority group. Problem type and demographical data would also be compared to identify patterns influencing referral behaviour.

3. The G.P. referral rates from the selected G.P. practices could be examined for priority referral patterns over a period of several years. It may be possible to establish associations between referral patterns and waiting list periods.

SUMMARY:

This pilot study set out to investigate differences between General Practitioner priority referrals and non-priority referrals. The results support the hypothesis that priority referral letters demonstrate more of the characteristics of referral urgency than non-priority referral letters. This evidence suggests that G.P.'s are referring on some assessment of need. However, analysis of differences between priority and non-priority clients on measures of symptomatology and life impairment, reveals that such differences are non-significant. That priority referrals are not represented by significantly higher levels of distress or life interference may suggest that G.P. priority referrals are being made on the basis of poor assessment or non-need criteria. The analysis of between-practice referral rates, reveals considerable variation in priority referrals and provides further evidence that referral urgency may be a feature of G.P. referring behaviours rather than expected client need. Were such a hypothesis to be validated by the results of a large scale study, then the implications for Clinical Psychology are profound. The management of waiting lists would have to include a consideration of options such as a screening/assessment approach and the training of G.P.'s in appropriate referral behaviours.

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PATIENT QUESTIONNAIRE

(BAKER AND MCFADYEN, 1988)

This booklet asks you questions about how you have been feeling recently (last 2-3 weeks).

There is no need to spend ages on each question - a first reaction is usually the best. If you get tired of answering questions it's O.K. to take a break and come back to it later.

our answers will be regarded as strictly confidential

Time

Address

.....

Telephone Today's Date

☐ Male ☐ Female

ge

Marital status (please tick) ☐ Single ☐ 1st ☐ 2nd ☐ 3+ ☐ Co-habiting ☐ Separated ☐ Widowed ☐ Divorced

Marriage Marriage Marriage

Number of Children Ages

Occupation

Husband's/Wife's
Occupation

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Compiled by Roger Baker and Malcolm McFadyen, Community Services Department of Clinical Psychology, Psychology, 36 Cornhill Road, Aberdeen. December 1988.

INSTRUCTIONS

Here are some descriptions of how you may have felt, thought, or acted recently. After reading each statement you have to put a circle round either "False" or "True", depending upon which is the correct answer for you. On the occasions when you have marked "True", you then have to indicate how much this upset you. Do this by putting a circle round the one phrase or word which best explains this.

If you have marked "False" with a circle you would just go on to the next statement.

EXAMPLES

- A. Recently my concentration has been poor
 If true, this has upset me: ~~False~~
A bit True
A lot Unbearably

This first example would mean that recently your concentration has been poor, which upset you a bit

- B. Recently people have been getting on my nerves
 If true, this has upset me: False
Unbearably True
A lot A bit

The second example would mean that recently people have NOT been getting on your nerves

NOW PLEASE BEGIN

- | | | | | |
|----|--|------------------|-------|------------|
| 1. | Recently I have been breathless <i>or</i> had a pounding of my heart. | False | True | |
| | If true, this has upset me: | A bit | A lot | Unbearably |
| 2. | Recently I have lost the use of one of my arms or legs for a time. | False | True | |
| | If true, this has upset me: | Unbearably | A lot | A bit |
| 3. | Recently I have been <i>unnecessarily</i> careful about carrying out even simple everyday tasks. | False | True | |
| | If true, this has upset me: | A bit | A lot | Unbearably |
| 4. | Recently the future has seemed hopeless. | False | True | |
| | If true, how hopeless? | A bit | A lot | Completely |
| 5. | Recently I have been afraid of heights. | False | True | |
| | If true, this has upset me: | Unbearably | A lot | A bit |
| 6. | Recently I have had nagging doubts about nearly everything that I have done. | False | True | |
| | If true, this has upset me: | Unbearably | A lot | A bit |
| 7. | Recently I have been sleep-walking. | False | True | |
| | If true, this has upset me: | Unbearably | A lot | A bit |

- | | | | | |
|---|-----------------------------|---------------------|---------------|------------|
| 8. Recently, for no good reason, I have had feelings of panic. | If true, this has upset me: | False
Unbearably | True
A lot | A bit |
| 9. Recently I lost my sight <i>or</i> hearing for a while and then it came back. | If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 10. Recently I have been unable to stop myself from counting, <i>or</i> tapping things, <i>or</i> uttering phrases quite <i>pointlessly</i> . | If true, this has upset me: | False
Unbearably | True
A lot | A bit |
| 11. Recently I have lost interest in just about <i>everything</i> . | If true, how much loss? | False
Complete | True
A lot | A bit |
| 12. Recently I have had a fear of some harmless animal <i>or</i> insect. | If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 13. Recently I have been afraid of the thought that I might make a physical attack on someone. | If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 14. Recently I have lost my memory and forgotten who I was, <i>or</i> where I lived. | If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 15. Recently I have been so "worked up" that I couldn't sit still. | If true, this has upset me: | False
Unbearably | True
A lot | A bit |
| 16. Recently I have had pains which <i>moved</i> about to different parts of my body. | If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 17. Recently I have had to keep on checking things again and again <i>quite unnecessarily</i> . | If true, this has upset me: | False
Unbearably | True
A lot | A bit |
| 18. Recently I have been so depressed that I have thought of doing away with myself. | If true, how seriously? | False
Completely | True
Very | Not very |
| 19. Recently I have been afraid of handling some weapon or sharp object. | If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 20. Recently I have had an <i>unreasonable</i> fear that I might forget to do something and then something <i>really awful</i> might happen. | If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 21. Recently all my behaviour became like that of a young child for quite some time. | If true, this has upset me: | False
A bit | True
A lot | Unbearably |

2. Recently I have had a pain *or* tense feeling in my neck *or* head.
 If true, this has upset me: Unbearably A lot A bit
3. Recently I have often had difficulty in keeping my balance.
 If true, this has upset me: A bit A lot Unbearably
4. Recently I have kept having to wash myself *again and again*.
 If true, this has upset me: Unbearably A lot A bit
5. Recently I have been so miserable that I have had difficulty with my sleep.
 If true, this has upset me: Unbearably A lot A bit
6. Recently I have had an *unreasonable* fear of germs.
 If true, this has upset me: A bit A lot Unbearably
7. Recently I have had nagging fears that someone close to me might be killed or seriously injured.
 If true, this has upset me: A bit A lot Unbearably
8. Recently people around me have seemed strange, unfamiliar, or different.
 If true, are they *really*? Not really Not sure Really are
9. Recently I have worried about every little thing.
 If true, this has upset me: Unbearably A lot A bit
10. Recently I have been unable to control my violent shaking.
 If true, this has upset me: A bit A lot Unbearably
11. Recently I have felt *compelled* to do things in a certain order, *or* a certain number of times, to guard against something going wrong.
 If true, this has upset me: Unbearably A lot A bit
12. Recently I have been so low in spirits that I have sat for ages doing absolutely nothing.
 If true, this has upset me: Unbearably A lot A bit
13. Recently I have had a fear of enclosed spaces.
 If true, this has upset me: A bit A lot Unbearably
14. Recently nasty thoughts *or* words have kept running through my mind against *my will*.
 If true, this has upset me: A bit A lot Unbearably
15. Recently things around me have seemed odd, unfamiliar, or changed.
 If true, are they really odd or do they just seem so? Not really Not sure Really are

- | | | | |
|---|----------------------|---------------|------------|
| 36. Recently worrying has kept me awake at night.
If true, this has upset me: | False
Unbearably | True
A lot | A bit |
| 37. Recently I had fits.
If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 38. Recently I have had to wash things <i>again and again</i> to make absolutely certain that they were safe.
If true, this has upset me: | False
Unbearably | True
A lot | A bit |
| 39. Recently I have been depressed without knowing why.
If true, this has upset me: | False
Extremely | True
Very | Fairly |
| 40. Recently I have been frightened of going into crowds or social gatherings.
If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 41. Recently I have been worried by the thought that certain things might have been left lying around.
If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 42. Recently I have lost consciousness for a few seconds without actually falling.
If true, this has upset me: | False
A bit | True
A lot | Unbearable |
| 43. Recently I have been so anxious that I couldn't make up my mind about the simplest thing.
If true, how anxious? | False
Extremely | True
Very | Fairly |
| 44. Recently I have had burning <i>or</i> tingling sensations under my skin which were much worse than "pins and needles".
If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 45. Recently I have felt <i>compelled</i> to keep on touching things.
If true, this has upset me: | False
Unbearably | True
A lot | A bit |
| 46. Recently I have gone to bed not caring if I never woke up.
If true, how serious was this? | False
Desperately | True
Very | Fairly |
| 47. Recently I have been quite unable to bring myself to go out alone.
If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 48. Recently I have had persistent feelings of having left something unfinished without knowing what.
If true, this has upset me: | False
A bit | True
A lot | Unbearably |
| 49. Recently I have found myself in some place without knowing <i>why</i> I was there or <i>how</i> I got there.
If true, this has upset me: | False
A bit | True
A lot | Unbearably |

Now please check that you have circled "False" or "True" for every statement: and when "True" was marked that one of the three choices is also circled.

INSTRUCTIONS

Choose a number from the sliding scale below to show how much the various areas of your life are impaired or restricted because of your problems and write it in the box opposite each problem.

0 1 2 3 4 5 6 7 8

Not at all impaired or restricted	Slightly impaired/ restricted	Definitely impaired/ restricted	Markedly impaired/ restricted	Very Severely impaired/I can't do these things
---	-------------------------------------	---------------------------------------	-------------------------------------	--

NOTE: If any area does not apply to you, write N/A

Work

☐

Home management (cleaning, tidying, shopping, cooking, looking after home and or children)

☐

Social leisure activities (with other people, eg parties, pubs, clubs, outings, visits, dating, home entertainment)

☐

Private leisure activities (done alone, eg reading, gardening, collecting, sewing, walking alone)

☐

Family relationships (including relationship with husband/wife)

☐

Sexual relations

☐

Any other areas of your life which are impaired or restricted because of your problems? Please describe and rate

.....

☐

.....

☐

THANKYOU FOR FILLING IN THIS QUESTIONNAIRE

STATISTICAL RESULTS - CSS. PATIENT QUESTIONNAIRE - PRIORITY v NON-PRIORITY GROUPS

css/3: basic stats	T-test; indep.var: URGENT [1 gr.= YES] [2 gr.= NO] N. of Cases = 83 [from 173] (MD c-w del)					
	2-TAILED t	TEST p-level	1 group N1	2 group N2	1 group Mean	2 group Mean
wwork	1.694	.094	43	45	2.930233	2.066667
whome	.255	.799	43	45	2.232558	2.111111
wsoc_im	-1.247	.216	43	45	2.895349	3.533333
wprivate	.683	.497	43	45	2.093023	1.755556
wfamily	.204	.839	43	45	3.395349	3.288889
wsexlife	.420	.675	43	45	3.627907	3.355556
dnoanx	-1.126	.263	43	45	3.674419	4.177778
dsevanx	-.715	.476	43	45	6.372093	7.088889
dnoconv	.704	.483	43	45	.883721	.711111
dsevconv	.611	.543	43	45	1.418605	1.155556
dno_obs	1.042	.300	43	45	1.441860	1.133333
dsev_obs	1.110	.270	43	45	2.139535	1.577778
dno_dep	.609	.544	43	45	3.720930	3.422222
dsev_dep	1.237	.220	43	45	6.558140	5.288889
dnophob	-.226	.822	43	45	1.186047	1.244444
dsev_pho	-.053	.958	43	45	1.930233	1.955556
dno_rumi	1.511	.134	43	45	2.372093	1.666667
dsev_rum	1.092	.278	43	45	3.720930	2.844444
dno_diss	.273	.785	43	45	.720930	.666667
dsevdiss	.079	.937	43	45	1.162791	1.133333

css/3: basic stats	T-test; indep.var: URGENT [1 gr.= YES] [2 gr.= NO] N. of Cases = 88 [from 173] (MD c-w del)			
	1 group St. Dev.	2 group St. Dev.	H0 : F	SD1=SD2 p-level
wwork	2.491847	2.290296	1.184	.581
whome	2.368817	2.091348	1.283	.416
wsoc_im	2.399301	2.398863	1.000	.997
wprivate	2.428148	2.206968	1.210	.532
wfamily	2.460541	2.427328	1.028	.928
wsexlife	2.862094	3.199116	1.249	.470
dnoanx	2.134980	2.059224	1.075	.812
dsevanx	4.654866	4.742565	1.038	.905
dnoconv	1.294849	.991377	1.706	.083
dsevconv	2.280691	1.731468	1.735	.073
dno_obs	1.484881	1.289820	1.325	.358
dsev_obs	2.596531	2.137212	1.476	.204
dno_dep	2.538518	2.050376	1.533	.164
dsev_dep	5.487225	4.065499	1.822	.052
dnophob	1.200314	1.227628	1.046	.885
dsev_pho	2.333966	2.152753	1.175	.597
dno_rumi	2.681713	1.581139	2.877	.001
dsev_rum	4.113425	3.397563	1.466	.213
dno_diss	.934156	.929320	1.010	.971
dsevdiss	1.771873	1.726794	1.053	.865

css/3: basic stats	T-test; indep.var: URGENT [1 gr.= YES] [2 gr.= NO] N. of Cases = 164 [from 172]					
	2-TAILED t	TEST p-level	1 group N1	2 group N2	1 group Mean	2 group Mean
dno_anx+dep	1.737	.084	77	87	8.01299	6.90805
dsev anx+dep	1.965	.051	77	87	13.71429	11.12644

css/3: basic stats	T-test; indep.var: URGENT [1 gr.= YES] [2 gr.= NO] N. of Cases = 164 [from 172]			
	1 group St. Dev.	2 group St. Dev.	H0 : F	SD1=SD2 p-level
dno_anx+dep dsev anx+dep	4.225529 9.334229	3.916667 7.509381	1.164 1.545	.493 .051

css/3: basic stats	T-test; indep.var: sex [1 gr.= MALE] [2 gr.= FEMALE] N. of Cases = 87 [from 173] (MD c-w del)					
	2-TAILED t	TEST p-level	1 group N1	2 group N2	1 group Mean	2 group Mean
URGENT	.937	.351	27	60	1.592593	1.483333
work	1.539	.128	27	60	3.000000	2.186667
whome	1.121	.263	27	60	2.592593	2.016667
wsoc_im	.827	.411	27	60	3.553556	3.091667
wprivate	-.045	.965	27	60	1.925926	1.950000
wfamily	.550	.584	27	60	3.592593	3.283333
wsexlife	.514	.609	27	60	3.777778	3.416667
dnoanx	.786	.434	27	60	4.185185	3.800000
dsevanx	-.174	.863	27	60	6.592593	6.783333
dnoconv	-.749	.456	27	60	1.666667	1.866667
dsevconv	-.695	.489	27	60	1.074074	1.400000
dno_obs	.754	.453	27	60	1.444444	1.200000
dsev_obs	.646	.520	27	60	2.074074	1.716667
dno_dep	.998	.321	27	60	3.962963	3.433333
dsev_dep	-.003	.997	27	60	5.962963	5.966667
dnophob	-.613	.541	27	60	1.111111	1.283333
dsev_pho	-.940	.350	27	60	1.629630	2.116667
dno_rumi	.488	.627	27	60	2.185185	1.933333
dsev_rum	-.027	.978	27	60	3.259259	3.283333
dno_diss	1.525	.131	27	60	.925926	.600000
dsevdiss	.883	.380	27	60	1.407407	1.050000

css/3: basic stats	T-test; indep.var: sex [1 gr.= MALE] [2 gr.= FEMALE] N. of Cases = 87 [from 173] (MD c-w del)			
	1 group St. Dev.	2 group St. Dev.	H0 : F	SD1=SD2 p-level
URGENT	.500712	.503939	1.013	.996
work	2.056883	2.450643	1.420	.328
whome	2.098704	2.266122	1.166	.682
wsoc_im	2.606697	2.335234	1.246	.479
wprivate	2.384661	2.302725	1.072	.800
wfamily	2.223290	2.511611	1.276	.501
wsexlife	3.042435	3.026950	1.010	.941
dnoanx	1.981395	2.169121	1.198	.624
dsevanx	4.643103	4.780226	1.060	.897
dnoconv	1.414214	1.016252	1.937	.037
dsevconv	2.463986	1.796418	1.881	.046
dno_obs	1.250641	1.459045	1.361	.391
dsev_obs	2.251938	2.443196	1.177	.661
dno_dep	2.278351	2.294922	1.015	1.000
dsev_dep	4.484859	5.008354	1.247	.544
dnophob	1.086042	1.263459	1.353	.400
dsev_pho	1.964065	2.344063	1.424	.324
dno_rumi	1.902165	2.356863	1.535	.231
dsev_rum	3.737467	3.844836	1.058	.900
dno_diss	.997147	.886815	1.264	.451
dsevdiss	1.759791	1.741079	1.022	.915